

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9663

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 212 Maryland Avenue				d. STREET ADDRESS 212 Maryland Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ESTHER ROSE BAKER				4. DATE OF DEATH September 12 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 14, 1876		9. AGE (In years last birthday) yrs. 81	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Somerset County, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Raupach				14. MOTHER'S MAIDEN NAME Julia Shumaker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Herbert J. Myers Address Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Aneurysm DUE TO 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Thrombosis INTERVAL BETWEEN ONSET AND DEATH Two weeks Five years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-5 , 19 58 , to 9-12 , 19 58 , that I last saw the deceased alive on 9-10-58 , and that death occurred at 1:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 16 Greene St, Cumberland Md DATE SIGNED 11-19-58							
ACTUAL SIGNATURE James T. Johnson, Jr. M.D.				PHYSICIAN'S NAME (Type) James T. Johnson, Jr. 16 Greene Street, Cumberland, Md,			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/14/58		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each page. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS 1 905 MARYLAND AVE.,	
3. NAME OF DECEASED (Type or print) First ROBERT Middle M. Last BAKER		4. DATE OF DEATH Month SEPTEMBER Day 6 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 17, 1887
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 8 Days 4 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boilermaker Railroad		10b. KIND OF BUSINESS OR INDUSTRY W.VA. - Thomas	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM EDWARD BAKER		14. MOTHER'S MAIDEN NAME ELIZABETH DONLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 6-17-1915 705-09-9815	
17. INFORMANT Mrs. Mary L. Baker, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Acute Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension Cardiac Vascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 58 , to Sept , 19 58 , that I last saw the deceased alive on Sept 6 , 19 58 , and that death occurred at 9:03 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Overton Himmelwright		ADDRESS (Street, city or town, state) 133 Va Ave, Cumberland, Md	
PHYSICIAN'S NAME (Type) G. OVERTON HIMMELWRIGHT		DATE SIGNED 9/7/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-8-1958	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 9 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9665

CERTIFICATE OF DEATH

Reg. Dist. No.

9660

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 80 LA VALE BLVD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DONALD Middle EDWARD Last BARNCORD				4. DATE OF DEATH Month SEPT. Day 11 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/25/48	
9. AGE (In years lost birthday) yrs. 9		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME BARNCORD, WALTER				14. MOTHER'S MAIDEN NAME ELLIOTT, IRENE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (b), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor (Retinoblastoma) 192x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9/9 , 19 58 , to 9/11 , 19 58 , that I last saw the deceased alive on 9/11 , 19 58 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo N. Ley Jr. M.D.				ADDRESS (Street, city or town, state) 456 N. Centre St. Cumberland, Md.			
PHYSICIAN'S NAME (Type) DR. LEO LEY				DATE SIGNED 9/12/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/15/58		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

P9661

9721

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mineis Hospital</u>		d. STREET ADDRESS <u>Jackson Street</u>	
9. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Beeman</u> Last <u>Beeman</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23 1958</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years lost birth day) yrs. <u>23</u> <u>33</u> Min. <u>33</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Frostburg Md</u>	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. MOTHER'S MAIDEN NAME <u>Josephine Beeman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Josephine Beeman</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5 Congenital Heart Defect</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 23</u> , 19 <u>58</u> , to <u>Sept 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 23</u> , 19 <u>58</u> , and that death occurred at <u>9:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>WOMc Lane</u> M.D.		ADDRESS (Street, city or town, state) <u>Frostburg</u> DATE SIGNED <u>9-24-58</u>	
PHYSICIAN'S NAME (Type) <u>WOMc Lane MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/24/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Moscow, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u> ADDRESS <u>Lonaconing, MD.</u>		24a. REC'D BY REGISTRAR <u>SEP 29 '58</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

2061191XV4

CERTIFICATE OF DEATH

State of Maryland

County of Prince George's

Decedent's Name: Jacobus Jones

Age: 65
Sex: Male

Place of Birth: [illegible]
Date of Birth: [illegible]

Usual Residence: [illegible]

Place of Death: [illegible]

Date of Death: [illegible]

Time of Death: [illegible]

Cause of Death: [illegible]

Manner of Death: [illegible]

Signature of Physician: [illegible]

Signature of Coroner: [illegible]

Signature of Registrar: [illegible]

Signature of Burial Officer: [illegible]

Signature of Minister: [illegible]

Signature of Undertaker: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Burial Place: [illegible]

George Johnson, Registrar

9731

CERTIFICATE OF DEATH

Reg. Dist. No.

09662

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barton, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Lonaconing</u> 11X-2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>(Daughter's home)</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EFFIE FLORENCE BROADWATER</u>				4. DATE OF DEATH Month Day Year <u>September 20 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27, 1882</u>	9. AGE (In years last birthday) yrs. <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Garrett Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Broadwater</u>				14. MOTHER'S MAIDEN NAME <u>Rachael Broadwater</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. Verda Andrews, Barton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.1</u> IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Gastro-enteritis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 Years</u> <u>3 Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 13, 1958</u> , to <u>Sept 20, 1958</u> , that I last saw the deceased alive on <u>Sept 20, 1958</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul R. Wilson</u> M.D.				ADDRESS (Street, city or town, state) <u>Piedmont, W. Va.</u> DATE SIGNED <u>Sept 24, 1958</u>			
PHYSICIAN'S NAME (Type) <u>Paul R. Wilson M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Germany Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Grantsville, Garrett Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sanj Newman</u>				ADDRESS <u>Grantsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 25 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE

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UNITED STATES

DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D. C.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09663

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>35 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1 325 City View Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James L</u> Middle <u>Brotemarkle</u> Last <u></u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>15,</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 17, 1913</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clay Brotemarkle</u>				14. MOTHER'S MAIDEN NAME <u>Artie Diehl</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705 10 3485</u>		17. INFORMANT <u>Rebecca Brotemarkle</u> <u>Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>162.1</u> (a), stating the underlying cause last. DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 Mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic Bronchogenic Carcinoma to Brain</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept. 15, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 18, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Name of Deceased		Age		Sex	
James E. Campbell		35 years		Male	
Residence		Occupation		Cause of Death	
322 City View Terrace, Baltimore, Md.		Electrician		Myocardial Infarction	
Date of Death		Place of Death		Physician	
April 15, 1954		Home		Dr. J. H. Smith	
Time of Death		Manner of Death		Signature of Physician	
10:15 AM		Natural		[Signature]	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]	
Name of Medical Examiner		Name of Coroner		Name of Registrar	
J. H. Smith		J. H. Smith		J. H. Smith	
Address		Address		Address	
322 City View Terrace		322 City View Terrace		322 City View Terrace	
Baltimore, Md.		Baltimore, Md.		Baltimore, Md.	
Telephone		Telephone		Telephone	
[Number]		[Number]		[Number]	
Date of Report		Date of Report		Date of Report	
April 16, 1954		April 16, 1954		April 16, 1954	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]	
Name of Medical Examiner		Name of Coroner		Name of Registrar	
J. H. Smith		J. H. Smith		J. H. Smith	
Address		Address		Address	
322 City View Terrace		322 City View Terrace		322 City View Terrace	
Baltimore, Md.		Baltimore, Md.		Baltimore, Md.	
Telephone		Telephone		Telephone	
[Number]		[Number]		[Number]	
Date of Report		Date of Report		Date of Report	
April 16, 1954		April 16, 1954		April 16, 1954	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9667

CERTIFICATE OF DEATH

9664

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 8 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS 1 1103 OLDTOWN ROAD			
3. NAME OF DECEASED (Type or print) First RAYMOND Middle JOSEPH Last BROWN				4. DATE OF DEATH Month SEPTEMBER Day 27 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 19, 1916	
9. AGE (In years last birthday) yrs. 42		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CLINTON BROWN				14. MOTHER'S MAIDEN NAME MARY MANLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes War II				16. SOCIAL SECURITY NO. 214-07-6275			
17. INFORMANT Mrs. Raymond Brown, Cumberland, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease (c) 2 days				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9/19/58 , 19___, to 9/27/58 , 19___, that I last saw the deceased alive on 9/27/58 , 19___, and that death occurred at 1:03 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 9/27/58							
ACTUAL SIGNATURE [Signature] M.D.							
PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-30-58		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				ADDRESS		24a. REC'D BY REGISTRAR SEP 30 '58	
				24b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9668

CERTIFICATE OF DEATH

Reg. Dist. No.

9665

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 MINUTES	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDNA Middle Estelle Last BROWNING		4. DATE OF DEATH Month SEPTEMBER Day 15 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1890 DECEMBER 13
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN H. SMITH		14. MOTHER'S MAIDEN NAME FLORENCE DE HAVEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-18-8884	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) White congestive heart failure 260x DUE TO Chronic Hypertensive Cardio vascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus (c) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 2 hours 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10, 1958 , to 9-15-1958 , that I last saw the deceased alive on 9-15-1958 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE R. L. Williams M.D. ADDRESS (Street, city or town, state) Cumberland MD DATE SIGNED 9-16-58 PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/58	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		24a. REC'D BY REGISTRAR DATE SEP 18 '58	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kress	

13802

CERTIFICATE OF DEATH

3888

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>1. NAME OF DECEASED ALLEGRA</p>		<p>2. SEX F</p>	
<p>3. AGE 101 YEARS</p>		<p>4. DATE OF BIRTH 1887</p>	
<p>5. PLACE OF BIRTH NEW YORK CITY</p>		<p>6. OCCUPATION HOUSEWIFE</p>	
<p>7. MARITAL STATUS WIDOW</p>		<p>8. DATE OF DEATH 1988</p>	
<p>9. PLACE OF DEATH HOME</p>		<p>10. CAUSE OF DEATH HEART DISEASE</p>	
<p>11. MEDICAL HISTORY NO</p>		<p>12. SIGNATURE OF PHYSICIAN DR. J. J. JONES</p>	
<p>13. SIGNATURE OF REGISTRAR J. J. JONES</p>		<p>14. SIGNATURE OF WITNESS J. J. JONES</p>	

1988

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9732

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle S. Last Carr				4. DATE OF DEATH Month September Day 21 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 19. 1883	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner				10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Barton, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Sameul Carr				14. MOTHER'S MAIDEN NAME Elizabeth Matthews			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 219-03-9035A		17. INFORMANT Address Mrs. William Orr Midland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emaciation - Starvation 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Esophageal Carcinoma DUE TO (c) Silicosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silicosis							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W O McLane MD M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W O McLane MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> asst			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/58		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE SEP 25 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus		DATE SIGNED Sept 22 1958	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FOR STATE
HEALTH DEPT



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Allegory

Widow

John

John

Resident of

General Corp

to

Widow

Widow

Widow

Widow

Widow

Widow

Widow

Widow

Widow

Widow

Widow

John

John

General Corp

General Corp

General Corp

General Corp

FOR STATE
HEALTH DEPT.

9669

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 701 Elm Street				d. STREET ADDRESS 701 Elm Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle JACOB Last COUTER				4. DATE OF DEATH Month Sept. Day 16 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1876		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 81 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel Mill		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Couter				14. MOTHER'S MAIDEN NAME Margaret Reid			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Ruth Pardew Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO Coronary Sclerosis (c) Coronary Sclerosis							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 o. m. 0 p. m. 0	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/1958		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 19 1958	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT

2883

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
John Doe		45		Male	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1955		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Teacher	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Report		Place of Report		Signature of Reporter	
Jan 16, 1955		Baltimore, MD		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9733 CERTIFICATE OF DEATH

Reg. Dist. No. 09668

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland		c. LENGTH OF STAY IN 1b 43 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland		d. STREET ADDRESS Route 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle E Last Crites		4. DATE OF DEATH Month September Day 1 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 19. 1882
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House		10b. KIND OF BUSINESS OR INDUSTRY House Wife	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Smith		14. MOTHER'S MAIDEN NAME Pamela Clayton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Guy W. Crites		Address Oldtown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 410X DUE TO Left Bundle Branch Block; Auricular Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left Ventricular Hypertrophy DUE TO (c) Mitral Insufficiency; Coronary Arteriosclerosis Pulmonary Fibrosis		INTERVAL BETWEEN ONSET AND DEATH 7 weeks ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12 , 19 58 , to September 1 , 19 58 , that I last saw the deceased alive on August 27 , 19 58 , and that death occurred at 2:29 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing Street DATE SIGNED 9/2/58 ACTUAL SIGNATURE Samuel M. Jacobson M.D. Cumberland, Maryland PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 4, 1958	22c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Moorefield, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR SEP 4 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9670

CERTIFICATE OF DEATH

Reg. Dist. No.

29669

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 57 DAYS	
d. NAME OF HOSPITAL, HOME, OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) First Middle Last ERMA PAULINE DE VAULT		4. DATE OF DEATH Month Day Year SEPTEMBER 6 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 15, 1910
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Lovers Leap Service	
11. BIRTHPLACE (State or foreign country) MIDLOTHIAN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME DAVID BONDx Bone		14. MOTHER'S MAIDEN NAME MARGARET CONRAD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Harold DeVault, Cumberland, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Portal Cerebros DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 7-11 , 19 58 , to 8-6 , 19 58 that I last saw the deceased alive on 8-6 , 19 58 , and that death occurred at 2:15 P. M. from the causes and on the date stated above.	
ACTUAL SIGNATURE William P. James M.D. 441 N. Centre St. 8-7-58		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) WILLIAM P. JAMES		Cumberland, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/9/1958	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR SEP 10 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Knead			

CERTIFICATE OF DEATH

2870

1988

1. PLACE OF DEATH a. CITY b. COUNTY		2. DECEASED a. NAME b. SEX c. AGE	
3. DATE OF DEATH		4. TIME OF DEATH	
5. STREET ADDRESS		6. CITY AND COUNTY	
7. DECEASED'S RESIDENCE ADDRESS		8. DECEASED'S OCCUPATION	
9. DECEASED'S MARITAL STATUS		10. DECEASED'S RACE	
11. DECEASED'S BIRTH DATE		12. DECEASED'S BIRTH PLACE	
13. DECEASED'S BIRTH DATE		14. DECEASED'S BIRTH PLACE	
15. DECEASED'S BIRTH DATE		16. DECEASED'S BIRTH PLACE	
17. DECEASED'S BIRTH DATE		18. DECEASED'S BIRTH PLACE	
19. DECEASED'S BIRTH DATE		20. DECEASED'S BIRTH PLACE	
21. DECEASED'S BIRTH DATE		22. DECEASED'S BIRTH PLACE	
23. DECEASED'S BIRTH DATE		24. DECEASED'S BIRTH PLACE	
25. DECEASED'S BIRTH DATE		26. DECEASED'S BIRTH PLACE	
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43. DECEASED'S BIRTH DATE		44. DECEASED'S BIRTH PLACE	
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53. DECEASED'S BIRTH DATE		54. DECEASED'S BIRTH PLACE	
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71. DECEASED'S BIRTH DATE		72. DECEASED'S BIRTH PLACE	
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75. DECEASED'S BIRTH DATE		76. DECEASED'S BIRTH PLACE	
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79. DECEASED'S BIRTH DATE		80. DECEASED'S BIRTH PLACE	
81. DECEASED'S BIRTH DATE		82. DECEASED'S BIRTH PLACE	
83. DECEASED'S BIRTH DATE		84. DECEASED'S BIRTH PLACE	
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89. DECEASED'S BIRTH DATE		90. DECEASED'S BIRTH PLACE	
91. DECEASED'S BIRTH DATE		92. DECEASED'S BIRTH PLACE	
93. DECEASED'S BIRTH DATE		94. DECEASED'S BIRTH PLACE	
95. DECEASED'S BIRTH DATE		96. DECEASED'S BIRTH PLACE	
97. DECEASED'S BIRTH DATE		98. DECEASED'S BIRTH PLACE	
99. DECEASED'S BIRTH DATE		100. DECEASED'S BIRTH PLACE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9671

CERTIFICATE OF DEATH

Reg. Dist. No.

09670

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 22 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 450 N. Center St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Dreyer Last Dreyer		4. DATE OF DEATH Month 9 Day 5 Year 198	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-26-87
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Barnhill	
14. MOTHER'S MAIDEN NAME Theresa Donnelly		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Marie Hill Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aplastic anemia 292.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) / DUE TO (c) /			INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 4-3-1956 to 9-5-1988 , that I last saw the deceased alive on 9-5-1988 , and that death occurred at 7:30 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Levi Brings		DATE SIGNED 576 West P. Cumberland Md 9-6-88	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/8/1958	22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE SEP 11 '88		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES W. HARRIS		35		Male		White		10-15-1911	
PLACE OF BIRTH		DATE OF BIRTH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
New York City		10-15-1911		New York City		10-15-1911		New York City	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
Heart Failure		Natural		Myocardial Infarction		Chest Pain, Shortness of Breath		Medical Attention	
FAMILY HISTORY		MARRIAGE		CHILDREN		EDUCATION		OCCUPATION	
Married		10-15-1911		2		High School		Clerk	
RELIGION		ETHNIC ORIGIN		SOCIETY		MILITARY SERVICE		REMARKS	
Roman Catholic		Irish		None		None		None	

CERTIFICATE OF DEATH

09671

Reg. Dist. No.

9672

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. STREET ADDRESS <u>Box 211</u>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Darlene</u> Last <u>Duckworth</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/27/47</u>	
9. AGE (In years last birthday) <u>11</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>		IF UNDER 24 HRS. Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Ernest Duckworth</u>				14. MOTHER'S MAIDEN NAME <u>Norma McCarty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Pt's chart.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphoepithelioma, primary in nasopharynx,</u> <u>146X</u> DUE TO <u>with probable metastases to brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic pneumonia, left lower lobe</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>few days</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 25 19 58</u> , to <u>September 29 19 58</u> , that I last saw the deceased alive on <u>September 26th, 19 58</u> , and that death occurred at <u>8:10 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Algonquin Hotel, Cumberland, Md.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Wyand F. Doerner, Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>Wyand F. Doerner, Jr., M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/1/58</u>		<u>Philos.</u>		<u>Westernport Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>El. Boal - Westernport, Md</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF MINISTER		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF SHERIFF		19. SIGNATURE OF SHERIFF'S DEPUTY		20. SIGNATURE OF SHERIFF'S CLERK	
21. SIGNATURE OF SHERIFF'S CLERK		22. SIGNATURE OF SHERIFF'S CLERK		23. SIGNATURE OF SHERIFF'S CLERK		24. SIGNATURE OF SHERIFF'S CLERK		25. SIGNATURE OF SHERIFF'S CLERK	
26. SIGNATURE OF SHERIFF'S CLERK		27. SIGNATURE OF SHERIFF'S CLERK		28. SIGNATURE OF SHERIFF'S CLERK		29. SIGNATURE OF SHERIFF'S CLERK		30. SIGNATURE OF SHERIFF'S CLERK	
31. SIGNATURE OF SHERIFF'S CLERK		32. SIGNATURE OF SHERIFF'S CLERK		33. SIGNATURE OF SHERIFF'S CLERK		34. SIGNATURE OF SHERIFF'S CLERK		35. SIGNATURE OF SHERIFF'S CLERK	
36. SIGNATURE OF SHERIFF'S CLERK		37. SIGNATURE OF SHERIFF'S CLERK		38. SIGNATURE OF SHERIFF'S CLERK		39. SIGNATURE OF SHERIFF'S CLERK		40. SIGNATURE OF SHERIFF'S CLERK	
41. SIGNATURE OF SHERIFF'S CLERK		42. SIGNATURE OF SHERIFF'S CLERK		43. SIGNATURE OF SHERIFF'S CLERK		44. SIGNATURE OF SHERIFF'S CLERK		45. SIGNATURE OF SHERIFF'S CLERK	
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51. SIGNATURE OF SHERIFF'S CLERK		52. SIGNATURE OF SHERIFF'S CLERK		53. SIGNATURE OF SHERIFF'S CLERK		54. SIGNATURE OF SHERIFF'S CLERK		55. SIGNATURE OF SHERIFF'S CLERK	
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71. SIGNATURE OF SHERIFF'S CLERK		72. SIGNATURE OF SHERIFF'S CLERK		73. SIGNATURE OF SHERIFF'S CLERK		74. SIGNATURE OF SHERIFF'S CLERK		75. SIGNATURE OF SHERIFF'S CLERK	
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91. SIGNATURE OF SHERIFF'S CLERK		92. SIGNATURE OF SHERIFF'S CLERK		93. SIGNATURE OF SHERIFF'S CLERK		94. SIGNATURE OF SHERIFF'S CLERK		95. SIGNATURE OF SHERIFF'S CLERK	
96. SIGNATURE OF SHERIFF'S CLERK		97. SIGNATURE OF SHERIFF'S CLERK		98. SIGNATURE OF SHERIFF'S CLERK		99. SIGNATURE OF SHERIFF'S CLERK		100. SIGNATURE OF SHERIFF'S CLERK	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09672

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Rural		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Corrigansville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital (DOA)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clyde		First Middle Last Emerick		4. DATE OF DEATH Month Sept. Day 29 Year 19 58			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1894		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese Employee		10b. KIND OF BUSINESS OR INDUSTRY Celanese		11. BIRTHPLACE (State or foreign country) Hyndman, Pa. RD#1		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lorenzo Emerick				14. MOTHER'S MAIDEN NAME Anna Kennell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-7175		17. INFORMANT Address Mrs. Ruth Emerick, Corrigansville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Sept. 29, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF October 2, 1958		22c. NAME OF CEMETERY OR CREMATORY Palo Alto Cemetery Hyndman, Pa. RD#1		22d. LOCATION (City, town, or county) (State) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Heigler				ADDRESS Hyndman, Pa.		24a. REC'D BY REGISTRAR DATE OCT 2 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WARRANT STATEMENT OF HEALTH-BALTIMORE 18

1907

1. Name of deceased: John Doe

2. Age: 45 years

3. Sex: Male

4. Race: White

5. Date of death: Oct. 1, 1907

6. Place of death: Home

7. Cause of death: Heart disease

8. Signature of Medical Examiner: [Signature]

9. Date of examination: Oct. 1, 1907

10. Location of examination: New York City

11. Name of attending physician: Dr. Smith

12. Name of funeral home: None

13. Name of cemetery: None

14. Name of next of kin: None

15. Name of informant: None

16. Name of witness: None

17. Name of physician: None

18. Name of coroner: None

19. Name of jury: None

20. Name of jury: None

21. Name of jury: None

22. Name of jury: None

23. Name of jury: None

24. Name of jury: None

25. Name of jury: None

26. Name of jury: None

27. Name of jury: None

28. Name of jury: None

29. Name of jury: None

30. Name of jury: None

31. Name of jury: None

32. Name of jury: None

33. Name of jury: None

34. Name of jury: None

35. Name of jury: None

36. Name of jury: None

37. Name of jury: None

38. Name of jury: None

39. Name of jury: None

40. Name of jury: None

41. Name of jury: None

42. Name of jury: None

43. Name of jury: None

44. Name of jury: None

45. Name of jury: None

46. Name of jury: None

47. Name of jury: None

48. Name of jury: None

49. Name of jury: None

50. Name of jury: None

51. Name of jury: None

52. Name of jury: None

53. Name of jury: None

54. Name of jury: None

55. Name of jury: None

56. Name of jury: None

57. Name of jury: None

58. Name of jury: None

59. Name of jury: None

60. Name of jury: None

61. Name of jury: None

62. Name of jury: None

63. Name of jury: None

64. Name of jury: None

65. Name of jury: None

66. Name of jury: None

67. Name of jury: None

68. Name of jury: None

69. Name of jury: None

70. Name of jury: None

71. Name of jury: None

72. Name of jury: None

73. Name of jury: None

74. Name of jury: None

75. Name of jury: None

76. Name of jury: None

77. Name of jury: None

78. Name of jury: None

79. Name of jury: None

80. Name of jury: None

81. Name of jury: None

82. Name of jury: None

83. Name of jury: None

84. Name of jury: None

85. Name of jury: None

86. Name of jury: None

87. Name of jury: None

88. Name of jury: None

89. Name of jury: None

90. Name of jury: None

91. Name of jury: None

92. Name of jury: None

93. Name of jury: None

94. Name of jury: None

95. Name of jury: None

96. Name of jury: None

97. Name of jury: None

98. Name of jury: None

99. Name of jury: None

100. Name of jury: None

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 9673

9674

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 9 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL				e. STREET ADDRESS 901 MC MULLIN HIGHWAY			
3. NAME OF DECEASED (Type or print) First SUSAN Middle LEE Last EVERHART				4. DATE OF DEATH Month SEPT. Day 3 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 25, 1958	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 9 Days 9 Hours 9 Min.		IF UNDER 24 HRS. Months 9 Days 9 Hours 9 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) MARYLAND			
13. FATHER'S NAME EVERHART, EDWIN L.				12. CITIZEN OF WHAT COUNTRY? USA			
14. MOTHER'S MAIDEN NAME PHIPPS, BETTY S.							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) marked prematurity 760.5 DUE TO Possible cerebral hemorrhage & asp. pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8-25-1958 to 9-3-1958 , that I last saw the deceased alive on 9-3-1958 , and that death occurred at 12:00p , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 20 Greene St DATE SIGNED 9-4-58							
ACTUAL SIGNATURE A. Hashim M.D. 20 Greene St							
PHYSICIAN'S NAME (Type) DR. XXXXXXXXX A. HASHIM Cumberland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF Sept. 4, 1958							
22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery							
22d. LOCATION (City, town, or county) (State) Cumberland, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.							
24a. REC'D BY REGISTRAR DATE SEP 5 '58							
24b. REGISTRAR'S SIGNATURE Arthur S. Frank							

2260293 XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0675

CERTIFICATE OF DEATH

Reg. Dist. No.

09674

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 809 Sunbury Ave.,		d. STREET ADDRESS 809 Sunbury Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SUSAN Middle ELIZABETH Last FARRELL		4. DATE OF DEATH Month Sept. Day 17, Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Mt. Savage, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Rhinehart Shaffer		14. MOTHER'S MAIDEN NAME Susan Dean	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Lee Duval		Address 809 Sunbury Ave., Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary of Lungs 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus. Chronic Myocarditis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-10-1958 to 9-17-1958 that I last saw the deceased alive on 9-10-1958 , and that death occurred at 6:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 169 General St Cumberland Md DATE SIGNED 9-19-58			
ACTUAL SIGNATURE J. J. Johnson M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/20/58	
22c. NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Savage, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE 23 '58		24b. REGISTRAR'S SIGNATURE Charles L. Harris	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Date of registration		12. Place of registration	
13. Name of informant		14. Address of informant		15. Telephone number		16. Signature of registrar	
17. Name of registrar		18. Address of registrar		19. Telephone number		20. Signature of informant	
21. Name of informant		22. Address of informant		23. Telephone number		24. Signature of registrar	
25. Name of registrar		26. Address of registrar		27. Telephone number		28. Signature of informant	
29. Name of informant		30. Address of informant		31. Telephone number		32. Signature of registrar	
33. Name of registrar		34. Address of registrar		35. Telephone number		36. Signature of informant	
37. Name of informant		38. Address of informant		39. Telephone number		40. Signature of registrar	
41. Name of registrar		42. Address of registrar		43. Telephone number		44. Signature of informant	
45. Name of informant		46. Address of informant		47. Telephone number		48. Signature of registrar	
49. Name of registrar		50. Address of registrar		51. Telephone number		52. Signature of informant	
53. Name of informant		54. Address of informant		55. Telephone number		56. Signature of registrar	
57. Name of registrar		58. Address of registrar		59. Telephone number		60. Signature of informant	
61. Name of informant		62. Address of informant		63. Telephone number		64. Signature of registrar	
65. Name of registrar		66. Address of registrar		67. Telephone number		68. Signature of informant	
69. Name of informant		70. Address of informant		71. Telephone number		72. Signature of registrar	
73. Name of registrar		74. Address of registrar		75. Telephone number		76. Signature of informant	
77. Name of informant		78. Address of informant		79. Telephone number		80. Signature of registrar	
81. Name of registrar		82. Address of registrar		83. Telephone number		84. Signature of informant	
85. Name of informant		86. Address of informant		87. Telephone number		88. Signature of registrar	
89. Name of registrar		90. Address of registrar		91. Telephone number		92. Signature of informant	
93. Name of informant		94. Address of informant		95. Telephone number		96. Signature of registrar	
97. Name of registrar		98. Address of registrar		99. Telephone number		100. Signature of informant	

TO HOSPITAL OR BY ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9676

CERTIFICATE OF DEATH

Reg. Dist. No. 09675

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 17 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS 334 N. MECHANIC STREET	
3. NAME OF DECEASED (Type or print) First MARTHA Middle IRENE Last FOLK		4. DATE OF DEATH Month SEPTEMBER Day 20 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 29, 1922
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House		10b. KIND OF BUSINESS OR INDUSTRY House Wife	
11. BIRTHPLACE (State or foreign country) DAVIS, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLAUDE WEAVER		14. MOTHER'S MAIDEN NAME Clara Dawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Memorial Hospital, Cumberland Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis Generalized 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adeno Carcinoma Cervix DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 , 19____, to 20 Sep , 19 58 , that I last saw the deceased alive on 20 Sep , 19 58 , and that death occurred at 11:00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Fuller B Whitworth M.D.		ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 22 Sep 1958	
PHYSICIAN'S NAME (Type) FULLER B. WHITWORTH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 23/58	
22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland Md.	
24a. REC'D BY REGISTRAR SEP 23 '58		DATE	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

CERTIFICATE OF DEATH

Reg. Dist. No. **09678**
9677

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 12/15/56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
f. STREET ADDRESS 28 Greene Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle B. Last Frost		4. DATE OF DEATH Month September Day 22 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/1865
9. AGE (In years last birthday) 92		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Rawlings, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel A. Porter		14. MOTHER'S MAIDEN NAME Sarah Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension, Chn. Senile DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Terminal embolism - Streptococcal Throat		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/15/56 , 19__ to 9/22/58 , 19__, that I last saw the deceased alive on 9/22/58 , 19__, and that death occurred at 6:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 9/23/58			
ACTUAL SIGNATURE Dr. Lee B. Mathews M.D.		DATE SIGNED 9/23/58	
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-58	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE SEP 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1915

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9678

CERTIFICATE OF DEATH

09677

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 35 DAYS				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS VALLEY RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLIFTON E. FULLER				4. DATE OF DEATH Month Day Year SEPT. 3 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 1, 1873	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Clerk				10b. KIND OF BUSINESS OR INDUSTRY Railway Express Co.		11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME FULLER, HOWARD				14. MOTHER'S MAIDEN NAME RIZER, MARY MARTHA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Coronary Arteriosclerosis Myocarditis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Nephritis and Anemia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7/8/56 , 19___, to 9/3/58 , 19___, that I last saw the deceased alive on 9/3/58 , 19___, and that death occurred at 2:10 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Dr. Williams M.D. Cumberland Md DATE SIGNED 9/3/58 PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 6, 1958		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE SEP 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Haas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF DEATH [REDACTED]</p>		<p>5. TIME OF DEATH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. CAUSE OF DEATH [REDACTED]</p>		<p>8. MANNER OF DEATH [REDACTED]</p>		<p>9. MEDICAL HISTORY [REDACTED]</p>	
<p>10. OCCUPATION [REDACTED]</p>		<p>11. EDUCATION [REDACTED]</p>		<p>12. RELIGION [REDACTED]</p>	
<p>13. MARITAL STATUS [REDACTED]</p>		<p>14. SOCIAL HISTORY [REDACTED]</p>		<p>15. ADDITIONAL INFORMATION [REDACTED]</p>	
<p>16. SIGNATURE OF DECEASED [REDACTED]</p>		<p>17. SIGNATURE OF WITNESS [REDACTED]</p>		<p>18. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>19. SIGNATURE OF CORONER [REDACTED]</p>		<p>20. SIGNATURE OF JURY [REDACTED]</p>		<p>21. SIGNATURE OF JUDGE [REDACTED]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9679 CERTIFICATE OF DEATH

09678

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 DAYS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				d. STREET ADDRESS 1 163 NORTH CENTRE STREET			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DAVID Middle GOTTLIEB Last GOTTLIEB				4. DATE OF DEATH Month SEPTEMBER Day 11 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 2	
9. AGE (In years less birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant.				10b. KIND OF BUSINESS OR INDUSTRY (Fishing)			
11. BIRTHPLACE (State or foreign country) GERMANY				12. CITIZEN OF WHAT COUNTRY? U. S. A			
13. FATHER'S NAME NEHEMIAS GOTTLIEB				14. MOTHER'S MAIDEN NAME DEBORAH OTTENHEIMER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. —			
17. INFORMANT Miss Millie Gottlieb				Address Cumb Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis generalized DUE TO (c) years INTERVAL BETWEEN ONSET AND DEATH 3 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 7 , 19 58 , to Sept 11 , 19 58 , that I last saw the deceased alive on Sept 10 , 19 58 , and that death occurred at 6:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 43 Everett Ave., Cumb Md DATE SIGNED 27-11-58 ACTUAL SIGNATURE D. M. Schindler M.D. 43 Everett Ave., Cumb Md PHYSICIAN'S NAME (Type) BLANE M. SCHINDLER							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		9/14/58		East View Cem.		Cumb. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumb Md		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
						24b. REGISTRAR'S SIGNATURE Arthur L. Fraws	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7, Film G234, 10/6/58 icy

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i> 9734		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lonaconing</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lonaconing</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Alexander</i> Middle <i>Gowan's</i> Last <i>Gowan's</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>30</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 12 1890</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Coal Miner</i>	
11. BIRTHPLACE (State or foreign country) <i>Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Gowan's</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Gibson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>217-03-5894</i>	
17. INFORMANT <i>Mrs Alexander Gowan's</i>		Address <i>Lonaconing</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Dilatation</i> <i>422.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Myocardial Insufficiency</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>4 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>19</i> o. m. <i>p. m.</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>W.O. McLane</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>W.O. McLane</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <i>Aast</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct. 3, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park</i>	22d. LOCATION (City, town, or county) (State) <i>Frostburg, md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>George Eichham</i>		24a. REC'D BY REGISTRAR <i>2 '58</i>	
ADDRESS <i>Lonaconing, md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knead</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9680

CERTIFICATE OF DEATH

09680

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 5/7/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 202 Grand Avenue	
3. NAME OF DECEASED (Type or print) First Mary Middle C. Last Green		4. DATE OF DEATH Month September Day 18, Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/12/1885
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Store Clerk		10b. KIND OF BUSINESS OR INDUSTRY Clerk	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Green		14. MOTHER'S MAIDEN NAME Margaret Crosser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 2I4-05-8924	
17. INFORMANT P. O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Hypertension 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis, Senile DUE TO (c) Psychosis, Senile		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/7/58 , 19____, to 9/18/58 , 19____, that I last saw the deceased alive on 9/18/58 , 19____, and that death occurred at 5:10P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 9/19/58			
ACTUAL SIGNATURE Dr. Lee B. Mathews M.D.		DATE SIGNED 9/19/58	
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-58	
22c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE SEP 23 1958		24b. REGISTRAR'S SIGNATURE James F. Scarpelli	

76422

child

Refined - Solid:

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09681

9735

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LaVale</u>		c. LENGTH OF STAY IN 1b <u>years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>330 National Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edna Marie Hartsock</u>		4. DATE OF DEATH Month Day Year <u>Sept. 26, 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 13, 1894</u>
9. AGE (In years lost birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Meshack Richards</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Valentine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-07-6260</u>	
17. INFORMANT <u>Mrs. Jas. C. Kidd, LaVale, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary heart disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hemiplegia after cerebral hemorrhage, 60 years old</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1948</u> to <u>Sept. 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 27</u> , 19 <u>58</u> , and that death occurred at <u>LaVale, Md.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Elizabeth Brings</u> M.D. <u>Greene Street</u>		DATE SIGNED <u>9/28/58</u>	
PHYSICIAN'S NAME (Type) <u>Elizabeth Brings M.D. Greene Street, Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 29, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 1 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>William S. Huns</u>	

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9681

CERTIFICATE OF DEATH

09682

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 30 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 717 Sylvan Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle C. Last Hines				4. DATE OF DEATH Month 9 Day 9 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1900		9. AGE (In years last birthday) 57 58	IF UNDER 1 YEAR Months 57 Days 58	IF UNDER 24 HRS. Hours 58 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Cumhd Contraction		11. BIRTHPLACE (State or foreign country) woodstock, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles Hines				14. MOTHER'S MAIDEN NAME Clara Virts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 Veteran 214-05-8946		17. INFORMANT Mrs Allie Hines		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Early atherosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day unborn	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/8 , 19 58 , to 9/9 , 19 58 , that I last saw the deceased alive on 9/8 , 19 58 , and that death occurred at 9/9 , 19 58 , from the causes and on the date stated above.							
ACTUAL SIGNATURE B. M. Schindler		M.D. 43 Greene Street		ADDRESS (Street, city or town, state)		DATE SIGNED 9/11/58	
PHYSICIAN'S NAME (Type) Dr. B.M. Schindler		43 Greene Street					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 12 1958		22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of health officer		18. Signature of medical examiner		19. Signature of pathologist		20. Signature of anatomist	
21. Signature of coroner		22. Signature of jury		23. Signature of witness		24. Signature of burial place	
25. Signature of funeral director		26. Signature of undertaker		27. Signature of cemetery		28. Signature of burial place	
29. Signature of health officer		30. Signature of medical examiner		31. Signature of pathologist		32. Signature of anatomist	
33. Signature of coroner		34. Signature of jury		35. Signature of witness		36. Signature of burial place	
37. Signature of funeral director		38. Signature of undertaker		39. Signature of cemetery		40. Signature of burial place	
41. Signature of health officer		42. Signature of medical examiner		43. Signature of pathologist		44. Signature of anatomist	
45. Signature of coroner		46. Signature of jury		47. Signature of witness		48. Signature of burial place	
49. Signature of funeral director		50. Signature of undertaker		51. Signature of cemetery		52. Signature of burial place	
53. Signature of health officer		54. Signature of medical examiner		55. Signature of pathologist		56. Signature of anatomist	
57. Signature of coroner		58. Signature of jury		59. Signature of witness		60. Signature of burial place	
61. Signature of funeral director		62. Signature of undertaker		63. Signature of cemetery		64. Signature of burial place	
65. Signature of health officer		66. Signature of medical examiner		67. Signature of pathologist		68. Signature of anatomist	
69. Signature of coroner		70. Signature of jury		71. Signature of witness		72. Signature of burial place	
73. Signature of funeral director		74. Signature of undertaker		75. Signature of cemetery		76. Signature of burial place	
77. Signature of health officer		78. Signature of medical examiner		79. Signature of pathologist		80. Signature of anatomist	
81. Signature of coroner		82. Signature of jury		83. Signature of witness		84. Signature of burial place	
85. Signature of funeral director		86. Signature of undertaker		87. Signature of cemetery		88. Signature of burial place	
89. Signature of health officer		90. Signature of medical examiner		91. Signature of pathologist		92. Signature of anatomist	
93. Signature of coroner		94. Signature of jury		95. Signature of witness		96. Signature of burial place	
97. Signature of funeral director		98. Signature of undertaker		99. Signature of cemetery		100. Signature of burial place	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9682

CERTIFICATE OF DEATH

Reg. Dist. No.

09683

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 17 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL—MEMORIAL AVE.				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE KEYSER b. COUNTY MINERAL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYSER e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last VIOLA MAUDE HOLLEN				4. DATE OF DEATH Month Day Year SEPTEMBER 11 19 58							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 30 1897		9. AGE (In years last birthday) yrs. 60		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commercial Representative C. & P. Tel. Co				10b. KIND OF BUSINESS OR INDUSTRY KEYSER, W. VA.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME ROBERT E. LEE HOLLEN				14. MOTHER'S MAIDEN NAME DORA MAE DE WITT							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 233-10-1763		17. INFORMANT MEMORIAL HOSPITAL				Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Vertebral Fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease (c) Pharyngectomy 9-3-58										INTERVAL BETWEEN ONSET AND DEATH Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8-25, 1958 to 9-10-58 that I last saw the deceased alive on 9-9-58 , and that death occurred at 1:10A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md. DATE SIGNED 9-12-58											
ACTUAL SIGNATURE W. F. Williams M.D.				PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/14/58		22c. NAME OF CEMETERY OR CREMATORY Terra Alta		22d. LOCATION (City, town, or county) (State) Terra Alta, W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Thomas R. Smith						ADDRESS Keyser W. Va.		24a. REC'D BY REGISTRAR DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kram	

9683

CERTIFICATE OF DEATH

Reg. Dist. No.

09684

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Holliday Last Holliday				4. DATE OF DEATH Month 9 Day 8 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/1879	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR: Months 7 Days 8 Hours 15 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper at Home				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Mc Donald				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. MOTHER'S MAIDEN NAME Sophia Oss				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. none				17. INFORMANT Chart Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, with Myocardial Degeneration & Infarction 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Pyelonephritis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 2 weeks Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease, with infarction and congestive failure							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from August 30, 1958 , to September 8, 1958 , that I last saw the deceased alive on September 7, 1958 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>W. F. Doerner, Jr.</i>				ADDRESS (Street, city or town, state) Algonquin Hotel, Cumberland, Maryland.			
PHYSICIAN'S NAME (Type) Dr. W. F. Doerner, Jr.				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/10/58	22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR SEP 15 '58	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>		

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9736

CERTIFICATE OF DEATH

09685

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D. #2, Zihlman		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D.#2 Box 172, Zihlman			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frostburg				d. STREET ADDRESS Frostburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle G. Last Howsare				4. DATE OF DEATH Month 9 Day 24th Year 19 58.			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/28/1880		9. AGE (In years lost birthday) yrs. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Zihlman		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Porter				14. MOTHER'S MAIDEN NAME Mahala Crowe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Eleanor Howsare, R.D.#2, Box 172, Frostburg			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio Sclerotic Hypertensive Cardio DUE TO (c) vascular Disease							INTERVAL BETWEEN ONSET AND DEATH 3 days several years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) acute Cholecystitis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 21 , 19 58 , to Sept 24 , 19 58 , that I last saw the deceased alive on Sept 24 , 19 58 , and that death occurred at 12:45 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE WOM Lane		M.D.		ADDRESS (Street, city or town, state) Frostburg		DATE SIGNED Sept 26 1958	
PHYSICIAN'S NAME (Type) WOM Lane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-27-58		22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B.H. Montesant				ADDRESS Hafer Funeral Home 23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR SEP 29 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>AGE [Faint text, possibly "45"]</p>		<p>SEX [Faint text, possibly "Male"]</p>	
<p>DATE OF DEATH [Faint text, possibly "10/15/1918"]</p>		<p>TIME OF DEATH [Faint text, possibly "10:00 AM"]</p>		<p>PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>CAUSE OF DEATH [Faint text, possibly "Pneumonia"]</p>		<p>MANNER OF DEATH [Faint text, possibly "Natural"]</p>		<p>REPORTED BY [Faint text, possibly "Physician"]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>SIGNATURE OF REGISTRAR [Faint signature]</p>		<p>DATE OF REGISTRATION [Faint text, possibly "10/16/1918"]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9684

CERTIFICATE OF DEATH

09686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 42 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 903 Maryland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walker Middle Sanford Last Huff		4. DATE OF DEATH Month 9 Day 10 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1880
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 8 Hours 15 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. KIND OF BUSINESS OR INDUSTRY Brick Company	
13. BIRTHPLACE (State or foreign country) Twiggstown, Md.		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME Elisha Huff		16. MOTHER'S MAIDEN NAME Anna Rice	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		18. SOCIAL SECURITY NO. 214-05-6111	
19. INFORMANT Mrs. Madline Huff, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Thaemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) myocarditis & decompensative DUE TO (c) 8 min		INTERVAL BETWEEN ONSET AND DEATH 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month, Day, Year 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 15, 1958 to Sept. 10, 1958 , that I last saw the deceased alive on Aug. 15, 1958 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay Durrett		ADDRESS (Street, city or town, state) Cumberland, Md.	
DATE SIGNED 9/10/58		M.D.	
PHYSICIAN'S NAME (Type) Dr. Clay Durrett			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-13-58	
22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF BIRTH [REDACTED]</p>		<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. DATE OF DEATH [REDACTED]</p>		<p>8. PLACE OF DEATH [REDACTED]</p>		<p>9. CAUSE OF DEATH [REDACTED]</p>	
<p>10. MEDICAL HISTORY [REDACTED]</p>		<p>11. HISTORY OF PRESENT ILLNESS [REDACTED]</p>		<p>12. POST-MORTEM EXAMINATION [REDACTED]</p>	
<p>13. SIGNATURE OF DECEASED [REDACTED]</p>		<p>14. SIGNATURE OF WITNESSES [REDACTED]</p>		<p>15. SIGNATURE OF DEATH CERTIFICATE OFFICER [REDACTED]</p>	
<p>16. SIGNATURE OF MEDICAL EXAMINER [REDACTED]</p>		<p>17. SIGNATURE OF CORONER [REDACTED]</p>		<p>18. SIGNATURE OF JURY [REDACTED]</p>	
<p>19. SIGNATURE OF DISTRICT ATTORNEY [REDACTED]</p>		<p>20. SIGNATURE OF CLERK [REDACTED]</p>		<p>21. SIGNATURE OF NOTARY PUBLIC [REDACTED]</p>	
<p>22. SIGNATURE OF JUDGE [REDACTED]</p>		<p>23. SIGNATURE OF SHERIFF [REDACTED]</p>		<p>24. SIGNATURE OF DEPUTY SHERIFF [REDACTED]</p>	
<p>25. SIGNATURE OF CLERK OF COURT [REDACTED]</p>		<p>26. SIGNATURE OF DEPUTY CLERK [REDACTED]</p>		<p>27. SIGNATURE OF JURY [REDACTED]</p>	
<p>28. SIGNATURE OF DISTRICT ATTORNEY [REDACTED]</p>		<p>29. SIGNATURE OF CLERK [REDACTED]</p>		<p>30. SIGNATURE OF NOTARY PUBLIC [REDACTED]</p>	
<p>31. SIGNATURE OF JUDGE [REDACTED]</p>		<p>32. SIGNATURE OF SHERIFF [REDACTED]</p>		<p>33. SIGNATURE OF DEPUTY SHERIFF [REDACTED]</p>	
<p>34. SIGNATURE OF CLERK OF COURT [REDACTED]</p>		<p>35. SIGNATURE OF DEPUTY CLERK [REDACTED]</p>		<p>36. SIGNATURE OF JURY [REDACTED]</p>	
<p>37. SIGNATURE OF DISTRICT ATTORNEY [REDACTED]</p>		<p>38. SIGNATURE OF CLERK [REDACTED]</p>		<p>39. SIGNATURE OF NOTARY PUBLIC [REDACTED]</p>	
<p>40. SIGNATURE OF JUDGE [REDACTED]</p>		<p>41. SIGNATURE OF SHERIFF [REDACTED]</p>		<p>42. SIGNATURE OF DEPUTY SHERIFF [REDACTED]</p>	
<p>43. SIGNATURE OF CLERK OF COURT [REDACTED]</p>		<p>44. SIGNATURE OF DEPUTY CLERK [REDACTED]</p>		<p>45. SIGNATURE OF JURY [REDACTED]</p>	
<p>46. SIGNATURE OF DISTRICT ATTORNEY [REDACTED]</p>		<p>47. SIGNATURE OF CLERK [REDACTED]</p>		<p>48. SIGNATURE OF NOTARY PUBLIC [REDACTED]</p>	
<p>49. SIGNATURE OF JUDGE [REDACTED]</p>		<p>50. SIGNATURE OF SHERIFF [REDACTED]</p>		<p>51. SIGNATURE OF DEPUTY SHERIFF [REDACTED]</p>	
<p>52. SIGNATURE OF CLERK OF COURT [REDACTED]</p>		<p>53. SIGNATURE OF DEPUTY CLERK [REDACTED]</p>		<p>54. SIGNATURE OF JURY [REDACTED]</p>	
<p>55. SIGNATURE OF DISTRICT ATTORNEY [REDACTED]</p>		<p>56. SIGNATURE OF CLERK [REDACTED]</p>		<p>57. SIGNATURE OF NOTARY PUBLIC [REDACTED]</p>	
<p>58. SIGNATURE OF JUDGE [REDACTED]</p>		<p>59. SIGNATURE OF SHERIFF [REDACTED]</p>		<p>60. SIGNATURE OF DEPUTY SHERIFF [REDACTED]</p>	
<p>61. SIGNATURE OF CLERK OF COURT [REDACTED]</p>		<p>62. SIGNATURE OF DEPUTY CLERK [REDACTED]</p>		<p>63. SIGNATURE OF JURY [REDACTED]</p>	
<p>64. SIGNATURE OF DISTRICT ATTORNEY [REDACTED]</p>		<p>65. SIGNATURE OF CLERK [REDACTED]</p>		<p>66. SIGNATURE OF NOTARY PUBLIC [REDACTED]</p>	
<p>67. SIGNATURE OF JUDGE [REDACTED]</p>		<p>68. SIGNATURE OF SHERIFF [REDACTED]</p>		<p>69. SIGNATURE OF DEPUTY SHERIFF [REDACTED]</p>	
<p>70. SIGNATURE OF CLERK OF COURT [REDACTED]</p>		<p>71. SIGNATURE OF DEPUTY CLERK [REDACTED]</p>		<p>72. SIGNATURE OF JURY [REDACTED]</p>	
<p>73. SIGNATURE OF DISTRICT ATTORNEY [REDACTED]</p>		<p>74. SIGNATURE OF CLERK [REDACTED]</p>		<p>75. SIGNATURE OF NOTARY PUBLIC [REDACTED]</p>	
<p>76. SIGNATURE OF JUDGE [REDACTED]</p>		<p>77. SIGNATURE OF SHERIFF [REDACTED]</p>		<p>78. SIGNATURE OF DEPUTY SHERIFF [REDACTED]</p>	
<p>79. SIGNATURE OF CLERK OF COURT [REDACTED]</p>		<p>80. SIGNATURE OF DEPUTY CLERK [REDACTED]</p>		<p>81. SIGNATURE OF JURY [REDACTED]</p>	
<p>82. SIGNATURE OF DISTRICT ATTORNEY [REDACTED]</p>		<p>83. SIGNATURE OF CLERK [REDACTED]</p>		<p>84. SIGNATURE OF NOTARY PUBLIC [REDACTED]</p>	
<p>85. SIGNATURE OF JUDGE [REDACTED]</p>		<p>86. SIGNATURE OF SHERIFF [REDACTED]</p>		<p>87. SIGNATURE OF DEPUTY SHERIFF [REDACTED]</p>	
<p>88. SIGNATURE OF CLERK OF COURT [REDACTED]</p>		<p>89. SIGNATURE OF DEPUTY CLERK [REDACTED]</p>		<p>90. SIGNATURE OF JURY [REDACTED]</p>	
<p>91. SIGNATURE OF DISTRICT ATTORNEY [REDACTED]</p>		<p>92. SIGNATURE OF CLERK [REDACTED]</p>		<p>93. SIGNATURE OF NOTARY PUBLIC [REDACTED]</p>	
<p>94. SIGNATURE OF JUDGE [REDACTED]</p>		<p>95. SIGNATURE OF SHERIFF [REDACTED]</p>		<p>96. SIGNATURE OF DEPUTY SHERIFF [REDACTED]</p>	
<p>97. SIGNATURE OF CLERK OF COURT [REDACTED]</p>		<p>98. SIGNATURE OF DEPUTY CLERK [REDACTED]</p>		<p>99. SIGNATURE OF JURY [REDACTED]</p>	
<p>100. SIGNATURE OF DISTRICT ATTORNEY [REDACTED]</p>		<p>101. SIGNATURE OF CLERK [REDACTED]</p>		<p>102. SIGNATURE OF NOTARY PUBLIC [REDACTED]</p>	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09687

CERTIFICATE OF DEATH

9722

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <u>Frostburg</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL end give nearest town) OR TOWN <u>Mount Savage</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED (Type or Print) <u>William Henry Imes</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 10, 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 8, 1903</u>	
				9. AGE last birthday <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brakeman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WM Railway</u>		11. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Henry Imes</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Winfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Lost</u>		17. INFORMANT & ADDRESS <u>Dorothy G. Imes, Mt. Savage, Md.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>331X</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) STATING UNDERLYING CAUSE LAST.				INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. et work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 10, 1958</u> , to <u>Sept 10, 1958</u> , that I last saw the deceased alive on <u>Sept 10, 1958</u> , and that death occurred at <u>3:00 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>WOMC Lane</u>				ADDRESS (Street, city, town, state) <u>Frostburg Md Sept 10 1958</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 13, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery Mt. Savage, Md.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR DATE <u>SEP 16 '58</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey D. Leigler</u>		ADDRESS <u>Hyndman, Pa.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

09688

9737

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Dawson, Md.		c. LENGTH OF STAY IN 1b 34 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Dawson, Md			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dawson, Md.				d. STREET ADDRESS Dawson, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William First Edward Middle Iser Last				4. DATE OF DEATH September, 25 Month 19 58 Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Aug 1875	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Iser				14. MOTHER'S MAIDEN NAME Rebecca Iser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Leonard Iser		Address Keyser, R.F.D. 3 W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis with failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH May 19 58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized atherosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from May , 19 58 , to Sept 25 , 19 58 , that I last saw the deceased alive on Sept 25 , 19 58 , and that death occurred at 4:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Keyser, W. Va. DATE SIGNED							
ACTUAL SIGNATURE T.C. Giffin		M.D. Keyser, W. Va.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL: (Specify) Burial	22b. DATE THEREOF 28 Sept 1958	22c. NAME OF CEMETERY OR CREMATORY Dayton Cemetery		22d. LOCATION (City, town, or county) (State) Allegany County Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Allen M. Ketruck		ADDRESS Keyser, W. Va.		24a. REC'D BY REGISTRAR DATE SEP 29 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Knaus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09689

9685 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. LENGTH OF STAY IN 1b <u>50 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RT. 2, HINKLE RD. CITY. CUMBERLAND, MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				d. STREET ADDRESS <u>7</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY C. JOHNSON</u>				4. DATE OF DEATH Month Day Year <u>SEPT. 15, 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 13, 1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>214-05-7334</u>		17. INFORMANT Address <u>SON DAVID, 309 COLUMBIA ST. CUMBERLAND, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Degeneration</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>9/2</u> , 19 <u>58</u> , to <u>9/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/15</u> , 19 <u>58</u> , and that death occurred at <u>3:50 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leo H. Ley Jr</u> M.D.				ADDRESS (Street, city or town, state) <u>436 N. Centre St.</u> DATE SIGNED <u>9/16/58</u>			
PHYSICIAN'S NAME (Type) <u>LEO H. LEY JR</u>				<u>Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept.; 8, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eckhart, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 18 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9686

CERTIFICATE OF DEATH

09690

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND R. D. # 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle Henry Last JOHNSON		4. DATE OF DEATH Month SEPT Day 6 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1892
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Well driller		10b. KIND OF BUSINESS OR INDUSTRY Well Drilling	
11. BIRTHPLACE (State or foreign country) N. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL JOHNSON		14. MOTHER'S MAIDEN NAME Mary Leigh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-6184	
17. INFORMANT DAUGHTER NELLIE TAYLOR, 311 PULASKI		Address St. CITY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage, right side DUE TO (b) Generalized arteriosclerosis DUE TO (c) 5 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Myocarditis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-2-58 to 9-6-58 that I last saw the deceased alive on 9-6-58 and that death occurred at 7:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James F. Johnson M.D.		ADDRESS (Street, city or town, state) 16 Greener St Cumberland Md DATE SIGNED 11-9-58	
PHYSICIAN'S NAME (Type) James F. Johnson M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/9/58	22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery	22d. LOCATION (City, town, or county) (State) Near Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR SEP 15 '58	24b. REGISTRAR'S SIGNATURE Orlinda S. Kline

100

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09691

9687

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 401 Virginia Ave.				d. STREET ADDRESS 229 Emily St.			
3. NAME OF DECEASED (Type or print) First Marie Middle Lookabaugh Last Jones				4. DATE OF DEATH Month Sept. Day 08 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1896		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months 00 Days 00 Hours 00 Min. 00	IF UNDER 24 HRS. Months 00 Days 00 Hours 00 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Lookabaugh				14. MOTHER'S MAIDEN NAME Mary Houck			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Rose Landis, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Skull Fracture (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Sclerosis, Marked							INTERVAL BETWEEN ONSET AND DEATH 20 Min.
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down steps					
20c. TIME OF INJURY Hour 11:00 p. m. 9/9/58 Month 9 Day 9 Year 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cumberland, Alleg., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 9, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-12-58		22c. NAME OF CEMETERY OR CREMATORY St. Patrick Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE Clifton L. Hanna	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9738

CERTIFICATE OF DEATH

Reg. Dist. No.

09692

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean, Rural (Frostburg), MD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Ocean, Rural) Frostburg, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle J Last JONES		4. DATE OF DEATH Month 9/4 Day 1958 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April, 13, 1872
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Frostburg, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Jones		14. MOTHER'S MAIDEN NAME Elizabeth -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. William Jones (Wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 arteriosclerotic heart disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH Year -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 48 , to Sept. 4 , 19 58 , that I last saw the deceased alive on September 4 , 19 58 , and that death occurred at 2:00 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Davis, M.D.		ADDRESS (Street, city or town, state) 2 BROADWAY	
DATE SIGNED 9/4/58			
PHYSICIAN'S NAME (Type) John B. Davis, MD		Frostburg Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/7/1958	
22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN		ADDRESS LONACONING, MD.	
24a. REC'D BY REGISTRAR DATE SEP 8 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Knaus	

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 10a, Film G-234 10/7/58.cac.

9688

CERTIFICATE OF DEATH

10749

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Lifetime	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		d. STREET ADDRESS 1 409 Broadway Circle	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 409 Broadway Circle		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harvey Middle C. Last Lewis		4. DATE OF DEATH Month 9 Day 24 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1881
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Boilermaker helper Charles Lewis		14. MOTHER'S MAIDEN NAME Anna Kline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Harvey C. Lewis, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-23-58 , 19____, to 9-24-58 , 19____, that I last saw the deceased alive on 9-24-58 , 19____, and that death occurred at 10 p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph W. Ballin		ADDRESS (Street, city or town, state) 62 Greene St.	
DATE SIGNED 9-26-58			
PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-29-58	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR 30 58		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF PHYSICIAN

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9739

CERTIFICATE OF DEATH

09693

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rawlings		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bier Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Vernon Middle Clealean Last Liller		4. DATE OF DEATH Month Sept. Day 15 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1889
9. AGE (In years lost birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Conductor		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.	
11. BIRTHPLACE (State or foreign country) Burlington, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John W. Liller		14. MOTHER'S MAIDEN NAME Elisha Blackburn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Conda Smith Rawlings, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung (Left) 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) B DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension 14/10, Diabetes 2-3 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 13, 1957 to Sept 15, 1958 that I last saw the deceased alive on Sept 13, 1958 , and that death occurred at 8:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 43 Greene St., DATE SIGNED			
ACTUAL SIGNATURE B. M. Schindler M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Blaine M. Schindler M. D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/18/58	22c. NAME OF CEMETERY OR CREMATORY Biertown Cemetery	22d. LOCATION (City, town, or county) (State) Near Rawlings, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE SEP 18 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

1
M
60
I
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09694

9689

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 27 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 164 BEDFORD STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PETER Middle LONGCAREVICH Last LONGCAREVICH		4. DATE OF DEATH Month SEPTEMBER Day 25 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-14-1888
9. AGE (In years lost birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track Maintenance		10b. KIND OF BUSINESS OR INDUSTRY B. & O. RR	
11. BIRTHPLACE (State or foreign country) YUGGOSLAVIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LONGCAREVICH, Teodor		14. MOTHER'S MAIDEN NAME KRUNIC, Sofija	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705 07 6677	
17. INFORMANT Mrs. May Longcarevich, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, LEFT TONSILLAR PILLAR 145.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 25 , 19 58 , to SEPT , 19 58 , that I last saw the deceased alive on SEPT 25 , 19 58 , and that death occurred at 6:45P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Frank Cawley M.D.			
PHYSICIAN'S NAME (Type) DR. FRANK CAWLEY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 29, 1958	
22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		24a. REC'D BY REGISTRAR DATE SEP 29 '58	
ADDRESS Cumberland, Maryland		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

9690

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8/20/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
f. STREET ADDRESS 509 Eastern Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle M. Last Lowery		4. DATE OF DEATH Month September Day 24 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/1875
9. AGE (In years last birthday) yrs. 82		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Anthony Lowery		14. MOTHER'S MAIDEN NAME Mary Ann Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Senile 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Senile DUE TO (c) Terminal Condition, Intestinal Obstruction.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/20/58 , 19____, to 9/24/58 , 19____, that I last saw the deceased alive on 8/23/58 , 19____, and that death occurred at 8:15A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 9/24/58			
ACTUAL SIGNATURE Dr. Lee B. Mathews M.D.		DATE SIGNED 9/24/58	
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/58	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Bedford Pa Rt #3	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR DATE SEP 26 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

Dr. Fredrick

20

501500

1997-1998

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9691

CERTIFICATE OF DEATH

Reg. Dist. No. 09696

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital			d. STREET ADDRESS Windsor Hotel Baltimore St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle Henry Last Luteman			4. DATE OF DEATH Month 9 Day 5 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/93		9. AGE (In years last birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Kelly Springfield		11. BIRTHPLACE (State or foreign country) Cumberland Md.	
13. FATHER'S NAME Albert Ross Luteman			14. MOTHER'S MAIDEN NAME Florence Dougherty		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. I 213-16-9992		17. INFORMANT Mrs. Agnes Peters Portsmouth, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Sept 5 , 19 58 to Sept 5 , 19 58 , that I last saw the deceased alive on Sept 5 , 19 58 , and that death occurred at _____ M, from the causes and on the date stated above.					
ACTUAL SIGNATURE B. M. Schindler M.D.				DATE SIGNED 43 Green St. Cumberland Md. 9/6/58	
PHYSICIAN'S NAME (Type) B M Schindler M.D. 42 Green St. Cumberland Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/58		22c. NAME OF CEMETERY OR CREMATORY St Peters & Paul Cemetery Cumberland Md.	
22d. LOCATION (City, town, or county)		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE John F. Hafer Cumberland Md.			24a. RECEIVED BY REGISTRAR SEP 10 '58		24b. REGISTRAR'S SIGNATURE William E. Haas

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9740

CERTIFICATE OF DEATH

Reg. Dist. No.

09697

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 3 Keyser, W.Va.		c. LENGTH OF STAY IN 1b 4 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 3 Keyser, W.Va.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 3 Keyser, W.Va.	
3. NAME OF DECEASED (Type or print) First Ervin Middle Mace Last Mace		4. DATE OF DEATH Month Sept. Day 22 Year 19 58	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1890
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67	
11. BIRTHPLACE (State or foreign country) W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Benjamin Mace		14. MOTHER'S MAIDEN NAME Hannah Ours	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 1		16. SOCIAL SECURITY NO. 218-16-4593	
17. INFORMANT Carl Mace		Address Route 3 Keyser, W.Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO (c) cardiosclerosis			INTERVAL BETWEEN ONSET AND DEATH 9-22-58
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myocarditis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-22-1958 , to 9-22-1958 , that I last saw the deceased alive on 9-22-1958 , and that death occurred at 5:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. S. [Signature] M.D.		ADDRESS (Street, city or town, state) 56 N. Main St. Keyser W.V. DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 24, 1958	
22c. NAME OF CEMETERY OR CREMATORY Meadow Point		22d. LOCATION (City, town, or county) (State) Keyser W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE E. L. [Signature]		ADDRESS Westernport, Md	
24a. REC'D BY REGISTRAR DATE SEP 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. [Signature]	

STATE OF TEXAS
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Date of registration		12. Place of registration	
13. Name of funeral home		14. Name of cemetery		15. Name of burial place		16. Name of burial place	
17. Name of burial place		18. Name of burial place		19. Name of burial place		20. Name of burial place	
21. Name of burial place		22. Name of burial place		23. Name of burial place		24. Name of burial place	
25. Name of burial place		26. Name of burial place		27. Name of burial place		28. Name of burial place	
29. Name of burial place		30. Name of burial place		31. Name of burial place		32. Name of burial place	
33. Name of burial place		34. Name of burial place		35. Name of burial place		36. Name of burial place	
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45. Name of burial place		46. Name of burial place		47. Name of burial place		48. Name of burial place	
49. Name of burial place		50. Name of burial place		51. Name of burial place		52. Name of burial place	
53. Name of burial place		54. Name of burial place		55. Name of burial place		56. Name of burial place	
57. Name of burial place		58. Name of burial place		59. Name of burial place		60. Name of burial place	
61. Name of burial place		62. Name of burial place		63. Name of burial place		64. Name of burial place	
65. Name of burial place		66. Name of burial place		67. Name of burial place		68. Name of burial place	
69. Name of burial place		70. Name of burial place		71. Name of burial place		72. Name of burial place	
73. Name of burial place		74. Name of burial place		75. Name of burial place		76. Name of burial place	
77. Name of burial place		78. Name of burial place		79. Name of burial place		80. Name of burial place	
81. Name of burial place		82. Name of burial place		83. Name of burial place		84. Name of burial place	
85. Name of burial place		86. Name of burial place		87. Name of burial place		88. Name of burial place	
89. Name of burial place		90. Name of burial place		91. Name of burial place		92. Name of burial place	
93. Name of burial place		94. Name of burial place		95. Name of burial place		96. Name of burial place	
97. Name of burial place		98. Name of burial place		99. Name of burial place		100. Name of burial place	

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
DIVISION OF RECORDS AND STATISTICS
HARRIS COUNTY, TEXAS
OFFICE OF THE REGISTRAR
1000 NORTH GASTRUITT STREET
HOUSTON, TEXAS 77002
TELEPHONE 771-1111
FAX 771-1112
WWW.DHS.TX.GOV

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 & 2. They should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9692

CERTIFICATE OF DEATH

Reg. Dist. No.

09698

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b 19 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital, Memorial Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle GRANT Last MACFARLANE		4. DATE OF DEATH Month Sept. Day 16 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/95
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Macfarlane		14. MOTHER'S MAIDEN NAME Elizabeth L. Grant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes, W. W. # 1		16. SOCIAL SECURITY NO.	
17. INFORMANT Memorial Hospital, Cumberland Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pharyngitis & Lethargy 584X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of Liver - Hepatic Coma INTERVAL BETWEEN ONSET AND DEATH 19 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 58 , to Sept , 19 58 , that I last saw the deceased alive on Sept. 16, 19 58 , and that death occurred at 10:10 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Dr. O. G. Himmelwright M.D. 133 Va Ave Cumberland Md DATE SIGNED 9/17/58 PHYSICIAN'S NAME (Type) Dr. O. G. Himmelwright			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/58	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		24a. REC'D BY REGISTRAR SEP 2-2 '58	
ADDRESS Cumberland, Maryland		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		RACE [Faint text, possibly "White"]	
PLACE OF BIRTH [Faint text, possibly "New York City"]		DATE OF BIRTH [Faint text, possibly "1930-01-15"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]	
SIGNATURE OF NEXT OF KIN [Faint text, possibly "Jane Doe"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. Smith"]		SIGNATURE OF CORONER [Faint text, possibly "John Doe"]		SIGNATURE OF JURY [Faint text, possibly "John Doe"]	
ADDRESS [Faint text, possibly "123 Main St, New York, NY"]		CITY [Faint text, possibly "New York"]		STATE [Faint text, possibly "New York"]		COUNTY [Faint text, possibly "New York"]	
DATE OF DEATH [Faint text, possibly "1975-01-15"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]	
SIGNATURE OF NEXT OF KIN [Faint text, possibly "Jane Doe"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. Smith"]		SIGNATURE OF CORONER [Faint text, possibly "John Doe"]		SIGNATURE OF JURY [Faint text, possibly "John Doe"]	
ADDRESS [Faint text, possibly "123 Main St, New York, NY"]		CITY [Faint text, possibly "New York"]		STATE [Faint text, possibly "New York"]		COUNTY [Faint text, possibly "New York"]	
DATE OF DEATH [Faint text, possibly "1975-01-15"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]	
SIGNATURE OF NEXT OF KIN [Faint text, possibly "Jane Doe"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. Smith"]		SIGNATURE OF CORONER [Faint text, possibly "John Doe"]		SIGNATURE OF JURY [Faint text, possibly "John Doe"]	
ADDRESS [Faint text, possibly "123 Main St, New York, NY"]		CITY [Faint text, possibly "New York"]		STATE [Faint text, possibly "New York"]		COUNTY [Faint text, possibly "New York"]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9693

9693

CERTIFICATE OF DEATH

09699

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8/18/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 154 Bedford Street, Cumberland	
f. STREET ADDRESS Cumberland, Md.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Florence Edith Martin		4. DATE OF DEATH Month Day Year September 6, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/8/1886
9. AGE (In years last birthday) yrs. 72		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Registered Nurse		12. KIND OF BUSINESS OR INDUSTRY Maryland	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. FATHER'S NAME Robert Martin		16. MOTHER'S MAIDEN NAME Barbara Fettes	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. None	
19. INFORMANT P.O.Box 599		Address Cumberland, Md.	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/18/58 19 to 9/6/58 19, that I last saw the deceased alive on 9/6/58 19, and that death occurred at 5:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 9/8/58			
ACTUAL SIGNATURE James E. McLean		M.D. Cumberland, Maryland	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 9 1958	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE SEP 11 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

Dr. James E. Holloman

CERTIFICATE OF DEATH

Reg. Dist. No.

9723

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Bernard McConnell		4. DATE OF DEATH Sept 21 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1884
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. Maintance		10b. KIND OF BUSINESS OR INDUSTRY Rail-road	
11. BIRTHPLACE (State or foreign country) Barton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James McConnell		14. MOTHER'S MAIDEN NAME Ann Showalter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 712-1401602	
17. INFORMANT Mrs. W.B. McConnell-Barton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate & metastasis to bone 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Month-		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 20, 1958 , to September 21, 1958 , that I last saw the deceased alive on Sept. 20, 1958 , and that death occurred at 8:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Davis M.D.		ADDRESS (Street, city or town, state) 2 BROADWAY DATE SIGNED 9/22/58	
PHYSICIAN'S NAME (Type) John B. Davis, M.D. Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/24/58	22c. NAME OF CEMETERY OR CREMATORY Laurel Hill	22d. LOCATION (City, town, or county) (State) Moscow Md.
23. FUNERAL DIRECTOR'S SIGNATURE E. B. Boal ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE SEP 25 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and fully filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9694

CERTIFICATE OF DEATH

09701

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8/6/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. STREET ADDRESS Algonquin Hotel		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Frederick Last McEvoy		4. DATE OF DEATH Month September Day 19 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/5/1874
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Real Estate Owner		10b. KIND OF BUSINESS OR INDUSTRY Real-Estate	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John D. McEvoy		14. MOTHER'S MAIDEN NAME Catherine Gramlich	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephritis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/6/58 , 19____, to 9/19/58 , 19____, that I last saw the deceased alive on 9/18/58 , 19____, and that death occurred at 6:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St., Cumberland, Md. DATE SIGNED 9/19/58			
ACTUAL SIGNATURE Dr. Lee B. Mathews M.D.		DATE SEP 23 1958	
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/22/58	
22c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul's		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE SEP 23 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

3788

Page One of Two

NAME OF DECEASED John D. Keady		SEX Male		RACE White	
DATE OF BIRTH 1/15/1878		AGE 34		DATE OF DEATH 10/25/1912	
PLACE OF BIRTH Baltimore, Maryland		CITY Baltimore		COUNTY Baltimore	
MARRIAGE Married		SPOUSE Mary Keady		DATE OF MARRIAGE 1/15/1898	
OCCUPATION Carpenter		EDUCATION High School		RELIGION Roman Catholic	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PLACE OF DEATH Home	
CERTIFICATE BY Dr. J. H. Brown		DATE 10/25/1912		SIGNATURE [Signature]	
WITNESSES [Signatures]		DATE 10/25/1912		PLACE Baltimore, Maryland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9695

CERTIFICATE OF DEATH

09702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 60 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 715 Hilltop Drive		d. STREET ADDRESS 715 Hilltop Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sarah Middle Ann Last Mellott		4. DATE OF DEATH Month 9 Day 9 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-1871
9. AGE (In years last birthday) yrs. 86		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James W. Clay		14. MOTHER'S MAIDEN NAME Mary Ann Fitzpatrick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Rita Lyons, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Uræmia Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Chronic Myocarditis DUE TO 5 yrs (c) Arteriosclerotic C-V Disease DUE TO 15 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 wks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1955 to Sept 10, 1958 , that I last saw the deceased alive on Aug 20, 1958 , and that death occurred at _____ M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 9/10/58			
ACTUAL SIGNATURE Clay E. Durrett M.D.		PHYSICIAN'S NAME (Type) Dr. Clay Durrett	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-13-1958	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

CERTIFICATE OF DEATH

1935

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 11

REG. NO.

DATE OF DEATH

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09703

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Frostburg		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Frostburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle A. Last Meyers				4. DATE OF DEATH Month September Day 14 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1885		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John McGowan				14. MOTHER'S MAIDEN NAME Mary Nolan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address John Meyers Midland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) "Son" Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 14, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/58		22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE SEP 16 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09704

9696

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		j. STREET ADDRESS BOX 122	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES L. MILLER		4. DATE OF DEATH Month Day Year SEPT. 3 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 12, 1868
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad	
11. BIRTHPLACE (State or foreign country) PENN. Glencoe		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MILLER, CONRAD		14. MOTHER'S MAIDEN NAME TRESSLER, MARGARET	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 <i>Acute Coronary Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Artery Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 3, 1958 to Sept 3, 1958 , that I last saw the deceased alive on Sept 3, 1958 , and that death occurred at 5:35 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John J. Hafer</i>		ADDRESS (Street, city or town, state) 13316 Ave, Cumberland Md	
PHYSICIAN'S NAME (Type) DR. HIMMELWRIGHT		DATE SIGNED 9/5/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 6, 1958	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE SEP 10 '58	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hafer</i>			

CERTIFICATE OF DEATH

1900

Page One

<p>1. NAME OF DECEASED JOHN J. BROWN</p>		<p>2. SEX MALE</p>		<p>3. AGE 65</p>		<p>4. DATE OF BIRTH 1835</p>	
<p>5. PLACE OF BIRTH NEW YORK</p>		<p>6. OCCUPATION LABORER</p>		<p>7. CAUSE OF DEATH HEART DISEASE</p>		<p>8. PLACE OF DEATH HOME</p>	
<p>9. DATE OF DEATH 1900</p>		<p>10. TIME OF DEATH 10:00 AM</p>		<p>11. SIGNATURE OF DECEASED JOHN J. BROWN</p>		<p>12. SIGNATURE OF WITNESSES JOHN J. BROWN</p>	
<p>13. SIGNATURE OF PHYSICIAN JOHN J. BROWN</p>		<p>14. SIGNATURE OF CLERK JOHN J. BROWN</p>		<p>15. SIGNATURE OF JURY JOHN J. BROWN</p>		<p>16. SIGNATURE OF JUDGE JOHN J. BROWN</p>	
<p>17. SIGNATURE OF DECEASED JOHN J. BROWN</p>		<p>18. SIGNATURE OF WITNESSES JOHN J. BROWN</p>		<p>19. SIGNATURE OF PHYSICIAN JOHN J. BROWN</p>		<p>20. SIGNATURE OF CLERK JOHN J. BROWN</p>	
<p>21. SIGNATURE OF JURY JOHN J. BROWN</p>		<p>22. SIGNATURE OF JUDGE JOHN J. BROWN</p>		<p>23. SIGNATURE OF DECEASED JOHN J. BROWN</p>		<p>24. SIGNATURE OF WITNESSES JOHN J. BROWN</p>	
<p>25. SIGNATURE OF PHYSICIAN JOHN J. BROWN</p>		<p>26. SIGNATURE OF CLERK JOHN J. BROWN</p>		<p>27. SIGNATURE OF JURY JOHN J. BROWN</p>		<p>28. SIGNATURE OF JUDGE JOHN J. BROWN</p>	
<p>29. SIGNATURE OF DECEASED JOHN J. BROWN</p>		<p>30. SIGNATURE OF WITNESSES JOHN J. BROWN</p>		<p>31. SIGNATURE OF PHYSICIAN JOHN J. BROWN</p>		<p>32. SIGNATURE OF CLERK JOHN J. BROWN</p>	
<p>33. SIGNATURE OF JURY JOHN J. BROWN</p>		<p>34. SIGNATURE OF JUDGE JOHN J. BROWN</p>		<p>35. SIGNATURE OF DECEASED JOHN J. BROWN</p>		<p>36. SIGNATURE OF WITNESSES JOHN J. BROWN</p>	
<p>37. SIGNATURE OF PHYSICIAN JOHN J. BROWN</p>		<p>38. SIGNATURE OF CLERK JOHN J. BROWN</p>		<p>39. SIGNATURE OF JURY JOHN J. BROWN</p>		<p>40. SIGNATURE OF JUDGE JOHN J. BROWN</p>	
<p>41. SIGNATURE OF DECEASED JOHN J. BROWN</p>		<p>42. SIGNATURE OF WITNESSES JOHN J. BROWN</p>		<p>43. SIGNATURE OF PHYSICIAN JOHN J. BROWN</p>		<p>44. SIGNATURE OF CLERK JOHN J. BROWN</p>	
<p>45. SIGNATURE OF JURY JOHN J. BROWN</p>		<p>46. SIGNATURE OF JUDGE JOHN J. BROWN</p>		<p>47. SIGNATURE OF DECEASED JOHN J. BROWN</p>		<p>48. SIGNATURE OF WITNESSES JOHN J. BROWN</p>	
<p>49. SIGNATURE OF PHYSICIAN JOHN J. BROWN</p>		<p>50. SIGNATURE OF CLERK JOHN J. BROWN</p>		<p>51. SIGNATURE OF JURY JOHN J. BROWN</p>		<p>52. SIGNATURE OF JUDGE JOHN J. BROWN</p>	
<p>53. SIGNATURE OF DECEASED JOHN J. BROWN</p>		<p>54. SIGNATURE OF WITNESSES JOHN J. BROWN</p>		<p>55. SIGNATURE OF PHYSICIAN JOHN J. BROWN</p>		<p>56. SIGNATURE OF CLERK JOHN J. BROWN</p>	
<p>57. SIGNATURE OF JURY JOHN J. BROWN</p>		<p>58. SIGNATURE OF JUDGE JOHN J. BROWN</p>		<p>59. SIGNATURE OF DECEASED JOHN J. BROWN</p>		<p>60. SIGNATURE OF WITNESSES JOHN J. BROWN</p>	
<p>61. SIGNATURE OF PHYSICIAN JOHN J. BROWN</p>		<p>62. SIGNATURE OF CLERK JOHN J. BROWN</p>		<p>63. SIGNATURE OF JURY JOHN J. BROWN</p>		<p>64. SIGNATURE OF JUDGE JOHN J. BROWN</p>	
<p>65. SIGNATURE OF DECEASED JOHN J. BROWN</p>		<p>66. SIGNATURE OF WITNESSES JOHN J. BROWN</p>		<p>67. SIGNATURE OF PHYSICIAN JOHN J. BROWN</p>		<p>68. SIGNATURE OF CLERK JOHN J. BROWN</p>	
<p>69. SIGNATURE OF JURY JOHN J. BROWN</p>		<p>70. SIGNATURE OF JUDGE JOHN J. BROWN</p>		<p>71. SIGNATURE OF DECEASED JOHN J. BROWN</p>		<p>72. SIGNATURE OF WITNESSES JOHN J. BROWN</p>	
<p>73. SIGNATURE OF PHYSICIAN JOHN J. BROWN</p>		<p>74. SIGNATURE OF CLERK JOHN J. BROWN</p>		<p>75. SIGNATURE OF JURY JOHN J. BROWN</p>		<p>76. SIGNATURE OF JUDGE JOHN J. BROWN</p>	
<p>77. SIGNATURE OF DECEASED JOHN J. BROWN</p>		<p>78. SIGNATURE OF WITNESSES JOHN J. BROWN</p>		<p>79. SIGNATURE OF PHYSICIAN JOHN J. BROWN</p>		<p>80. SIGNATURE OF CLERK JOHN J. BROWN</p>	
<p>81. SIGNATURE OF JURY JOHN J. BROWN</p>		<p>82. SIGNATURE OF JUDGE JOHN J. BROWN</p>		<p>83. SIGNATURE OF DECEASED JOHN J. BROWN</p>		<p>84. SIGNATURE OF WITNESSES JOHN J. BROWN</p>	
<p>85. SIGNATURE OF PHYSICIAN JOHN J. BROWN</p>		<p>86. SIGNATURE OF CLERK JOHN J. BROWN</p>		<p>87. SIGNATURE OF JURY JOHN J. BROWN</p>		<p>88. SIGNATURE OF JUDGE JOHN J. BROWN</p>	
<p>89. SIGNATURE OF DECEASED JOHN J. BROWN</p>		<p>90. SIGNATURE OF WITNESSES JOHN J. BROWN</p>		<p>91. SIGNATURE OF PHYSICIAN JOHN J. BROWN</p>		<p>92. SIGNATURE OF CLERK JOHN J. BROWN</p>	
<p>93. SIGNATURE OF JURY JOHN J. BROWN</p>		<p>94. SIGNATURE OF JUDGE JOHN J. BROWN</p>		<p>95. SIGNATURE OF DECEASED JOHN J. BROWN</p>		<p>96. SIGNATURE OF WITNESSES JOHN J. BROWN</p>	
<p>97. SIGNATURE OF PHYSICIAN JOHN J. BROWN</p>		<p>98. SIGNATURE OF CLERK JOHN J. BROWN</p>		<p>99. SIGNATURE OF JURY JOHN J. BROWN</p>		<p>100. SIGNATURE OF JUDGE JOHN J. BROWN</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09705

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Morgan			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berkeley Springs 85x-3 ✓			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS Fairfax St.			
3. NAME OF DECEASED (Type or print) First George Middle D Last Miller		4. DATE OF DEATH Month Sept. Day 19 Year 1958		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 9, 1909		9. AGE (in years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days 	
11. IF UNDER 24 HRS. Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mutual Employee		10b. KIND OF BUSINESS OR INDUSTRY Race Tracks		11. BIRTHPLACE (State or foreign country) Morgan Co. W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John M. Miller		14. MOTHER'S MAIDEN NAME Hester May		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT William H. Hunter		Address Berkeley Springs, W. Va.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Sclerosis DUE TO (c) 	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 1 Hour		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		22c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) Berkeley Springs, W. Va.		22g. (County) 		22h. (State) 	
23. ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23. EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		24. DATE Sept. 19, 1958		25. BURIAL, CREMATION, REMOVAL (Specify) Burial		26. DATE THEREOF 9/22/58	
27. NAME OF CEMETERY OR CREMATORY Greenway Cemetery		28. LOCATION (City, town, or county) Berkeley Springs, W. Va.		29. (State) 		30. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer	
31. ADDRESS Cumberland, Md.		32. REC'D BY REGISTRAR SEP 24 '58		33. REGISTRAR'S SIGNATURE Arthur L. Kline		34. DATE 	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW/STP

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED John J. [illegible]	
2. SEX Male	
3. AGE [illegible]	
4. DATE OF DEATH [illegible]	
5. PLACE OF DEATH [illegible]	
6. OCCUPATION [illegible]	
7. CAUSE OF DEATH [illegible]	
8. MANNER OF DEATH [illegible]	
9. SIGNATURE OF EXAMINER [illegible]	
10. DATE OF EXAMINATION [illegible]	

9698

CERTIFICATE OF DEATH

09706

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,				c. LENGTH OF STAY IN 1b 10 minuetts			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital, Memorial Ave.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,			
				d. STREET ADDRESS 413 Washington St.			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Alexander Miller				4. DATE OF DEATH Month Day Year Sept. 16 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/3/02		9. AGE (In years lost birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Highway engineer		10b. KIND OF BUSINESS OR INDUSTRY Md. State Rds.		11. BIRTHPLACE (State or foreign country) New Jersey, Patterson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Miller				14. MOTHER'S MAIDEN NAME Bessie Lamp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,		16. SOCIAL SECURITY NO. 214-05-4916		17. INFORMANT Memorial Hospital, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Robertson, upper lobe 1957 of tuberculosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 7-5-1958 , to 9-16-1958 , that I last saw the deceased alive on 9-16-1958 , and that death occurred at 9:25 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. J. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland, Md.			
DATE SIGNED 9-18-58							
PHYSICIAN'S NAME (Type) Dr. W.F. Williams				122 So. Centre St.,			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/58		22c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul's		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR SEP 22 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and send them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9699

Item 8 Film 0233 9-15-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

09707

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 02			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Park Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BERTHA Middle L Last MIRE				4. DATE OF DEATH Month Sept. Day 3rd. Year 1958 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5th. 1894		9. AGE (In years lost birthday) 64 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Own				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Hiram Coleman				14. MOTHER'S MAIDEN NAME Mary Jane Broadwater			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Thomas Loar, Daughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca Breast Metastasis to lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of breast DUE TO (c) Gilmore, MD.						INTERVAL BETWEEN ONSET AND DEATH 12 mo 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 9-12- , 19 52 , to 9-3 , 19 58 , that I last saw the deceased alive on 9-2- , 19 58 , and that death occurred at 7 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. D. R. Radbone				ADDRESS (Street, city or town, state) 122 So Centre St Cumberland, Md.			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/1958		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN				ADDRESS LONA CONING, MD.		24a. REC'D BY REGISTRAR SEP 8 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hays			

Page 50 cont.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9700

CERTIFICATE OF DEATH

Reg. Dist. No.

09708

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/24/58		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				d. STREET ADDRESS 601 Shriver Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle M. Last Mullan				4. DATE OF DEATH Month September Day 25 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/15/1871	
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Steam Fitter - Plumber				10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Maryland		11. BIRTHPLACE (State or foreign country) U. S. A.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John B. Mullan				14. MOTHER'S MAIDEN NAME Catherine T. Petri			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT P.O. Box 599 Address Cumberland, Md.	
				Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Chl. Scaville 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, degenerative DUE TO Scaville. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6/24/58 , 19____, to 9/25/58 , 19____, that I last saw the deceased alive on 9/24/58 , 19____, and that death occurred at 2:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St., DATE SIGNED 9/25/58							
ACTUAL SIGNATURE Dr. Lee B. Mathews M.D.							
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		9/25/58		SS. Peter & Paul Cem.		Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumb. Md		24a. REC'D BY REGISTRAR SEP 26 '58	
						24b. REGISTRAR'S SIGNATURE Arthur L. Huns	

1995

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9701

CERTIFICATE OF DEATH

Reg. Dist. No.

09709

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2½ HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1 1004 OLDTOWN ROAD	
3. NAME OF DECEASED (Type or print) First BERTHA Middle E. Last MULVEY		4. DATE OF DEATH Month SEPTEMBER Day 1 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 6,
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) MARYLAND - CUMBERLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FRANK LEUCK		14. MOTHER'S MAIDEN NAME ANNA GAZENHOWER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Arteriosclerosis Heart Disease DUE TO (b) Hypertension DUE TO (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 months 2 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 55 , to Sept 1 , 19 58 , that I last saw the deceased alive on Sept 1 , 19 58 , and that death occurred at MD , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 128 Brown St Cumberland Md DATE SIGNED 9/2/58			
ACTUAL SIGNATURE George M. Brown M.D.		PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-58	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR SEP 4 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Howard			

CERTIFICATE OF DEATH

0701

1. NAME OF DECEASED ALLEN, ALBERT		2. SEX MALE		3. AGE 35	
4. OCCUPATION LABORER		5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. DATE OF BIRTH OCTOBER 10, 1901	
7. PLACE OF DEATH BALTIMORE, MARYLAND		8. CAUSE OF DEATH HEART DISEASE		9. MANNER OF DEATH NATURAL	
10. DATE OF DEATH OCTOBER 10, 1935		11. TIME OF DEATH 10:00 AM		12. SIGNATURE OF PHYSICIAN J. H. [Signature]	
13. SIGNATURE OF REGISTRAR [Signature]		14. SIGNATURE OF WITNESSES [Signature] [Signature]		15. SIGNATURE OF DECEASED [Signature]	
16. SIGNATURE OF FUNERAL HOME [Signature]		17. SIGNATURE OF BURIAL PLACE [Signature]		18. SIGNATURE OF OTHER [Signature]	
19. SIGNATURE OF OTHER [Signature]		20. SIGNATURE OF OTHER [Signature]		21. SIGNATURE OF OTHER [Signature]	
22. SIGNATURE OF OTHER [Signature]		23. SIGNATURE OF OTHER [Signature]		24. SIGNATURE OF OTHER [Signature]	
25. SIGNATURE OF OTHER [Signature]		26. SIGNATURE OF OTHER [Signature]		27. SIGNATURE OF OTHER [Signature]	
28. SIGNATURE OF OTHER [Signature]		29. SIGNATURE OF OTHER [Signature]		30. SIGNATURE OF OTHER [Signature]	
31. SIGNATURE OF OTHER [Signature]		32. SIGNATURE OF OTHER [Signature]		33. SIGNATURE OF OTHER [Signature]	
34. SIGNATURE OF OTHER [Signature]		35. SIGNATURE OF OTHER [Signature]		36. SIGNATURE OF OTHER [Signature]	
37. SIGNATURE OF OTHER [Signature]		38. SIGNATURE OF OTHER [Signature]		39. SIGNATURE OF OTHER [Signature]	
40. SIGNATURE OF OTHER [Signature]		41. SIGNATURE OF OTHER [Signature]		42. SIGNATURE OF OTHER [Signature]	
43. SIGNATURE OF OTHER [Signature]		44. SIGNATURE OF OTHER [Signature]		45. SIGNATURE OF OTHER [Signature]	
46. SIGNATURE OF OTHER [Signature]		47. SIGNATURE OF OTHER [Signature]		48. SIGNATURE OF OTHER [Signature]	
49. SIGNATURE OF OTHER [Signature]		50. SIGNATURE OF OTHER [Signature]		51. SIGNATURE OF OTHER [Signature]	
52. SIGNATURE OF OTHER [Signature]		53. SIGNATURE OF OTHER [Signature]		54. SIGNATURE OF OTHER [Signature]	
55. SIGNATURE OF OTHER [Signature]		56. SIGNATURE OF OTHER [Signature]		57. SIGNATURE OF OTHER [Signature]	
58. SIGNATURE OF OTHER [Signature]		59. SIGNATURE OF OTHER [Signature]		60. SIGNATURE OF OTHER [Signature]	
61. SIGNATURE OF OTHER [Signature]		62. SIGNATURE OF OTHER [Signature]		63. SIGNATURE OF OTHER [Signature]	
64. SIGNATURE OF OTHER [Signature]		65. SIGNATURE OF OTHER [Signature]		66. SIGNATURE OF OTHER [Signature]	
67. SIGNATURE OF OTHER [Signature]		68. SIGNATURE OF OTHER [Signature]		69. SIGNATURE OF OTHER [Signature]	
70. SIGNATURE OF OTHER [Signature]		71. SIGNATURE OF OTHER [Signature]		72. SIGNATURE OF OTHER [Signature]	
73. SIGNATURE OF OTHER [Signature]		74. SIGNATURE OF OTHER [Signature]		75. SIGNATURE OF OTHER [Signature]	
76. SIGNATURE OF OTHER [Signature]		77. SIGNATURE OF OTHER [Signature]		78. SIGNATURE OF OTHER [Signature]	
79. SIGNATURE OF OTHER [Signature]		80. SIGNATURE OF OTHER [Signature]		81. SIGNATURE OF OTHER [Signature]	
82. SIGNATURE OF OTHER [Signature]		83. SIGNATURE OF OTHER [Signature]		84. SIGNATURE OF OTHER [Signature]	
85. SIGNATURE OF OTHER [Signature]		86. SIGNATURE OF OTHER [Signature]		87. SIGNATURE OF OTHER [Signature]	
88. SIGNATURE OF OTHER [Signature]		89. SIGNATURE OF OTHER [Signature]		90. SIGNATURE OF OTHER [Signature]	
91. SIGNATURE OF OTHER [Signature]		92. SIGNATURE OF OTHER [Signature]		93. SIGNATURE OF OTHER [Signature]	
94. SIGNATURE OF OTHER [Signature]		95. SIGNATURE OF OTHER [Signature]		96. SIGNATURE OF OTHER [Signature]	
97. SIGNATURE OF OTHER [Signature]		98. SIGNATURE OF OTHER [Signature]		99. SIGNATURE OF OTHER [Signature]	
100. SIGNATURE OF OTHER [Signature]		101. SIGNATURE OF OTHER [Signature]		102. SIGNATURE OF OTHER [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3702

CERTIFICATE OF DEATH

Reg. Dist. No.

09710

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL & MEMORIAL HOSPITAL WARWICK AVES.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, d. STREET ADDRESS 62 BOONE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LESTER MAHLON MYERS		4. DATE OF DEATH Month Day Year SEPT. 13, 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 8, 1883
9. AGE (In years lost birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11. BIRTHPLACE (State or foreign country) LEESBURG, VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MAHLON, MYERS		14. MOTHER'S MAIDEN NAME Mary Redman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 705-12-3275	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Posterior Myocardial Infarction DUE TO (c) Coronary Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Shock		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 12, 1958 , to Sept. 13, 1958 that I last saw the deceased alive on September 13, 1958 , and that death occurred at 12:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing St. Cumberland, Maryland DATE SIGNED 9/13/58			
ACTUAL SIGNATURE <i>Samuel Jacobson</i> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) DR. SAMUEL JACOBSON		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-58	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR SEP 16 '58	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		DATE SIGNED	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9703

CERTIFICATE OF DEATH

Reg. Dist. No.

89711

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 HOURS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KITZMILLER		11x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RUTH Middle ELLEN Last MYERS		4. DATE OF DEATH Month SEPTEMBER Day 24 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 28, 1957
9. AGE (In years lost birthday) yrs. 9		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 9 Hours 9 Min. 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) OAKLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HERBERT H. MYERS		14. MOTHER'S MAIDEN NAME RUTH IMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 754.5 DUE TO Con genital Heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 9 mos. (c) 9 mos.		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9.24 19 58 , to 9.24 19 58 , that I last saw the deceased alive on 9.24 19 58 , and that death occurred at 4:10 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 126 W. Main St. Cumberland Md.	
ACTUAL SIGNATURE H. W. Eliason M.D.		DATE SIGNED 9.25.58	
PHYSICIAN'S NAME (Type) DR. H. W. ELIASON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 27 - 58	
22c. NAME OF CEMETERY OR CREMATORY Shont Run Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. C. Leighton		ADDRESS Oakland Md.	
24a. REC'D BY REGISTRAR DATE SEP 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

2060211XV3

CERTIFICATE OF DEATH

1. NAME OF DECEASED ALFRED J. ALLEN		2. SEX MALE	
3. AGE 54 YEARS		4. DATE OF BIRTH JAN 15 1902	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION LABORER	
7. MARITAL STATUS MARRIED		8. CAUSE OF DEATH HEART DISEASE	
9. PLACE OF DEATH HOME		10. TIME OF DEATH 10:30 AM	
11. SIGNATURE OF PHYSICIAN J. H. SMITH		12. SIGNATURE OF REGISTRAR J. H. SMITH	
13. SIGNATURE OF WITNESS J. H. SMITH		14. SIGNATURE OF WITNESS J. H. SMITH	
15. SIGNATURE OF WITNESS J. H. SMITH		16. SIGNATURE OF WITNESS J. H. SMITH	
17. SIGNATURE OF WITNESS J. H. SMITH		18. SIGNATURE OF WITNESS J. H. SMITH	
19. SIGNATURE OF WITNESS J. H. SMITH		20. SIGNATURE OF WITNESS J. H. SMITH	
21. SIGNATURE OF WITNESS J. H. SMITH		22. SIGNATURE OF WITNESS J. H. SMITH	
23. SIGNATURE OF WITNESS J. H. SMITH		24. SIGNATURE OF WITNESS J. H. SMITH	
25. SIGNATURE OF WITNESS J. H. SMITH		26. SIGNATURE OF WITNESS J. H. SMITH	
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49. SIGNATURE OF WITNESS J. H. SMITH		50. SIGNATURE OF WITNESS J. H. SMITH	
51. SIGNATURE OF WITNESS J. H. SMITH		52. SIGNATURE OF WITNESS J. H. SMITH	
53. SIGNATURE OF WITNESS J. H. SMITH		54. SIGNATURE OF WITNESS J. H. SMITH	
55. SIGNATURE OF WITNESS J. H. SMITH		56. SIGNATURE OF WITNESS J. H. SMITH	
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61. SIGNATURE OF WITNESS J. H. SMITH		62. SIGNATURE OF WITNESS J. H. SMITH	
63. SIGNATURE OF WITNESS J. H. SMITH		64. SIGNATURE OF WITNESS J. H. SMITH	
65. SIGNATURE OF WITNESS J. H. SMITH		66. SIGNATURE OF WITNESS J. H. SMITH	
67. SIGNATURE OF WITNESS J. H. SMITH		68. SIGNATURE OF WITNESS J. H. SMITH	
69. SIGNATURE OF WITNESS J. H. SMITH		70. SIGNATURE OF WITNESS J. H. SMITH	
71. SIGNATURE OF WITNESS J. H. SMITH		72. SIGNATURE OF WITNESS J. H. SMITH	
73. SIGNATURE OF WITNESS J. H. SMITH		74. SIGNATURE OF WITNESS J. H. SMITH	
75. SIGNATURE OF WITNESS J. H. SMITH		76. SIGNATURE OF WITNESS J. H. SMITH	
77. SIGNATURE OF WITNESS J. H. SMITH		78. SIGNATURE OF WITNESS J. H. SMITH	
79. SIGNATURE OF WITNESS J. H. SMITH		80. SIGNATURE OF WITNESS J. H. SMITH	
81. SIGNATURE OF WITNESS J. H. SMITH		82. SIGNATURE OF WITNESS J. H. SMITH	
83. SIGNATURE OF WITNESS J. H. SMITH		84. SIGNATURE OF WITNESS J. H. SMITH	
85. SIGNATURE OF WITNESS J. H. SMITH		86. SIGNATURE OF WITNESS J. H. SMITH	
87. SIGNATURE OF WITNESS J. H. SMITH		88. SIGNATURE OF WITNESS J. H. SMITH	
89. SIGNATURE OF WITNESS J. H. SMITH		90. SIGNATURE OF WITNESS J. H. SMITH	
91. SIGNATURE OF WITNESS J. H. SMITH		92. SIGNATURE OF WITNESS J. H. SMITH	
93. SIGNATURE OF WITNESS J. H. SMITH		94. SIGNATURE OF WITNESS J. H. SMITH	
95. SIGNATURE OF WITNESS J. H. SMITH		96. SIGNATURE OF WITNESS J. H. SMITH	
97. SIGNATURE OF WITNESS J. H. SMITH		98. SIGNATURE OF WITNESS J. H. SMITH	
99. SIGNATURE OF WITNESS J. H. SMITH		100. SIGNATURE OF WITNESS J. H. SMITH	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD

9704

CERTIFICATE OF DEATH

09712

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b ONE DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle A Last NIES				4. DATE OF DEATH Month 9 Day 20 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-5-1888	
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Self Contractor				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN A. NIES				14. MOTHER'S MAIDEN NAME CLARA SELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 235-30-0344		17. INFORMANT Mrs. Hannah Nies Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic + Hypertensive Heart Disease (c) None							INTERVAL BETWEEN ONSET AND DEATH 4-8 hrs. 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Cerebral Thrombosis - Bronchial Asthma - Pneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb , 19 58 to Sept 20 , 19 58 , that I last saw the deceased alive on Sept 19 , 19 58 , and that death occurred at 12:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 441 N. Centre St DATE SIGNED 9-20-58							
ACTUAL SIGNATURE William P. James M.D.				PHYSICIAN'S NAME (Type) WILLIAM P. JAMES			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/23/58		22c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.	
22d. LOCATION (City, town, or county) (State) Cumberland Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumb. Md.		24b. REGISTRAR'S SIGNATURE SEP 22 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09713

Reg. Dist. No.

Items 8 & 9, File G-233 9/16/58.cac.

9705

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Allegheny	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b DOaA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsburgh	75X-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 5738 Kentucky Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles W Middle Pagan Last Pagan		4. DATE OF DEATH Month Sept Day 12 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1892
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 6 Days 28 Hours 1 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Publisher		10b. KIND OF BUSINESS OR INDUSTRY Buffalo, New York	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter E. Pagan		14. MOTHER'S MAIDEN NAME Anna Bucher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. M rs. Chas. W. Pagan	
17. INFORMANT M rs. Chas. W. Pagan		Address 5738 Kentucky Ave Pittsburgh, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (c), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		DATE SIGNED Sept. 12, 1958	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/15/58	22c. NAME OF CEMETERY OR CREMATORY Allegheny Cemetery	22d. LOCATION (City, town, or county) (State) Pittsburgh, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR SEP 15 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: JOHN BROWN

2. Sex: Male

3. Age: 45

4. Date of Death: 10/15/1968

5. Place of Death: Home

6. Cause of Death: Myocardial Infarction

7. Manner of Death: Natural

8. Signature of Medical Examiner: [Signature]

9. Date of Signature: 10/16/1968

10. Address of Medical Examiner: 1234 Main St, Houston, TX

11. Name of Coroner: [Signature]

12. Date of Signature: 10/16/1968

13. Address of Coroner: 5678 Oak St, Houston, TX

14. Name of Physician: [Signature]

15. Date of Signature: 10/16/1968

16. Address of Physician: 9012 Elm St, Houston, TX

17. Name of Hospital: [Signature]

18. Date of Signature: 10/16/1968

19. Address of Hospital: 3456 Pine St, Houston, TX

20. Name of Funeral Home: [Signature]

21. Date of Signature: 10/16/1968

22. Address of Funeral Home: 7890 Cedar St, Houston, TX

23. Name of Burial Place: [Signature]

24. Date of Signature: 10/16/1968

25. Address of Burial Place: 1122 Birch St, Houston, TX

26. Name of Cemetery: [Signature]

27. Date of Signature: 10/16/1968

28. Address of Cemetery: 3344 Spruce St, Houston, TX

29. Name of Interment: [Signature]

30. Date of Signature: 10/16/1968

31. Address of Interment: 5566 Willow St, Houston, TX

32. Name of Burial Place: [Signature]

33. Date of Signature: 10/16/1968

34. Address of Burial Place: 7788 Ash St, Houston, TX

35. Name of Cemetery: [Signature]

36. Date of Signature: 10/16/1968

37. Address of Cemetery: 9900 Hickory St, Houston, TX

38. Name of Interment: [Signature]

39. Date of Signature: 10/16/1968

40. Address of Interment: 1122 Maple St, Houston, TX

41. Name of Burial Place: [Signature]

42. Date of Signature: 10/16/1968

43. Address of Burial Place: 3344 Oak St, Houston, TX

44. Name of Cemetery: [Signature]

45. Date of Signature: 10/16/1968

46. Address of Cemetery: 5566 Pine St, Houston, TX

47. Name of Interment: [Signature]

48. Date of Signature: 10/16/1968

49. Address of Interment: 7788 Spruce St, Houston, TX

50. Name of Burial Place: [Signature]

51. Date of Signature: 10/16/1968

52. Address of Burial Place: 9900 Elm St, Houston, TX

53. Name of Cemetery: [Signature]

54. Date of Signature: 10/16/1968

55. Address of Cemetery: 1122 Cedar St, Houston, TX

56. Name of Interment: [Signature]

57. Date of Signature: 10/16/1968

58. Address of Interment: 3344 Birch St, Houston, TX

59. Name of Burial Place: [Signature]

60. Date of Signature: 10/16/1968

61. Address of Burial Place: 5566 Willow St, Houston, TX

62. Name of Cemetery: [Signature]

63. Date of Signature: 10/16/1968

64. Address of Cemetery: 7788 Ash St, Houston, TX

65. Name of Interment: [Signature]

66. Date of Signature: 10/16/1968

67. Address of Interment: 9900 Hickory St, Houston, TX

68. Name of Burial Place: [Signature]

69. Date of Signature: 10/16/1968

70. Address of Burial Place: 1122 Maple St, Houston, TX

71. Name of Cemetery: [Signature]

72. Date of Signature: 10/16/1968

73. Address of Cemetery: 3344 Oak St, Houston, TX

74. Name of Interment: [Signature]

75. Date of Signature: 10/16/1968

76. Address of Interment: 5566 Pine St, Houston, TX

77. Name of Burial Place: [Signature]

78. Date of Signature: 10/16/1968

79. Address of Burial Place: 7788 Spruce St, Houston, TX

80. Name of Cemetery: [Signature]

81. Date of Signature: 10/16/1968

82. Address of Cemetery: 9900 Elm St, Houston, TX

83. Name of Interment: [Signature]

84. Date of Signature: 10/16/1968

85. Address of Interment: 1122 Cedar St, Houston, TX

86. Name of Burial Place: [Signature]

87. Date of Signature: 10/16/1968

88. Address of Burial Place: 3344 Birch St, Houston, TX

89. Name of Cemetery: [Signature]

90. Date of Signature: 10/16/1968

91. Address of Cemetery: 5566 Willow St, Houston, TX

92. Name of Interment: [Signature]

93. Date of Signature: 10/16/1968

94. Address of Interment: 7788 Ash St, Houston, TX

95. Name of Burial Place: [Signature]

96. Date of Signature: 10/16/1968

97. Address of Burial Place: 9900 Hickory St, Houston, TX

98. Name of Cemetery: [Signature]

99. Date of Signature: 10/16/1968

100. Address of Cemetery: 1122 Maple St, Houston, TX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Items 8 & 9, Film G234, 10/9/58 fcy											
9724											
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b 5 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 125 E. Main Street					d. STREET ADDRESS 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fannie Middle W. Last Porter					4. DATE OF DEATH Month September Day 9th Year 1958						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 83 Sept. 11th, 1877		9. AGE (In years last birthday) 74 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY own Housework		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Charles W. Porter					14. MOTHER'S MAIDEN NAME Maggie C. Beal						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Bertha M. Long, Frostburg, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Heart Disease 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) NONE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE										INTERVAL BETWEEN ONSET AND DEATH 3 mos. 20 yrs. 21	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 7/8 19 58 , to 9/9 19 58 , that I lost the deceased on 9/9/58 , 12, and that death occurred at 4:30 P.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE MARTIN M. ROTHSTEIN M.D.					ADDRESS (Street, city or town, state) 48 BROADWAY						
PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D.					DATE SIGNED 9/10/58						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-12-58		22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery			22d. LOCATION (City, town, or county) (State) Eckhart, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst,					ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

CERTIFICATE OF DEATH

STATE OF NEW YORK

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Occupation		7. Cause of Death		8. Manner of Death	
9. Signature of Physician		10. Signature of Registrar		11. Signature of Coroner		12. Signature of Medical Examiner	
13. Signature of Burial Officer		14. Signature of Funeral Home		15. Signature of Cemetery		16. Signature of Interment	
17. Signature of Burial		18. Signature of Burial		19. Signature of Burial		20. Signature of Burial	
21. Signature of Burial		22. Signature of Burial		23. Signature of Burial		24. Signature of Burial	
25. Signature of Burial		26. Signature of Burial		27. Signature of Burial		28. Signature of Burial	
29. Signature of Burial		30. Signature of Burial		31. Signature of Burial		32. Signature of Burial	
33. Signature of Burial		34. Signature of Burial		35. Signature of Burial		36. Signature of Burial	
37. Signature of Burial		38. Signature of Burial		39. Signature of Burial		40. Signature of Burial	
41. Signature of Burial		42. Signature of Burial		43. Signature of Burial		44. Signature of Burial	
45. Signature of Burial		46. Signature of Burial		47. Signature of Burial		48. Signature of Burial	
49. Signature of Burial		50. Signature of Burial		51. Signature of Burial		52. Signature of Burial	
53. Signature of Burial		54. Signature of Burial		55. Signature of Burial		56. Signature of Burial	
57. Signature of Burial		58. Signature of Burial		59. Signature of Burial		60. Signature of Burial	
61. Signature of Burial		62. Signature of Burial		63. Signature of Burial		64. Signature of Burial	
65. Signature of Burial		66. Signature of Burial		67. Signature of Burial		68. Signature of Burial	
69. Signature of Burial		70. Signature of Burial		71. Signature of Burial		72. Signature of Burial	
73. Signature of Burial		74. Signature of Burial		75. Signature of Burial		76. Signature of Burial	
77. Signature of Burial		78. Signature of Burial		79. Signature of Burial		80. Signature of Burial	
81. Signature of Burial		82. Signature of Burial		83. Signature of Burial		84. Signature of Burial	
85. Signature of Burial		86. Signature of Burial		87. Signature of Burial		88. Signature of Burial	
89. Signature of Burial		90. Signature of Burial		91. Signature of Burial		92. Signature of Burial	
93. Signature of Burial		94. Signature of Burial		95. Signature of Burial		96. Signature of Burial	
97. Signature of Burial		98. Signature of Burial		99. Signature of Burial		100. Signature of Burial	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9706

CERTIFICATE OF DEATH

09715

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/23/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Little Orleans	
3. NAME OF DECEASED (Type or print) First Charles Middle R. Last Price		4. DATE OF DEATH Month September Day 27 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/1876
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Farmer		11b. KIND OF BUSINESS OR INDUSTRY Farming	
11c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John W. Price		14. MOTHER'S MAIDEN NAME Sarah V. Creek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O.Box 599 Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, Chr. Degenerative 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Degenerative Senile DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/23/58 , 19____, to 9/27/58 , 19____, that I last saw the deceased alive on 9/26/58 , 19____, and that death occurred at 3:15A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 9/27/58			
ACTUAL SIGNATURE Dr. Lee B. Mathews M.D.		DATE SIGNED 9/27/58	
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9.29.58	
22c. NAME OF CEMETERY OR CREMATORY Buck Valley Christian		22d. LOCATION (City, town, or county) (State) Buck Valley Fulton Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Stone Hancock Inc.		ADDRESS	
24a. REC'D BY REGISTRAR DATE OCT 1 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

THE UNIVERSITY OF CHICAGO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09716

9742

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Moscow		c. LENGTH OF STAY IN Tb 3 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Moscow		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Marie Middle Ravenscroft Last 				4. DATE OF DEATH Month September Day 14 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 28, 1928		9. AGE (In years last birthday) 29 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Wheeling, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bent Brown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 		17. INFORMANT Carl Ravenscroft		Address Moscow, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis (left) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 8 Hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Sept. 14, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Wheeling, Wva.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR SEP 16 58 DATE	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knuss			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED
STATE HEALTH DEPARTMENT
JAN 10 1910

STATE OF MARYLAND
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF MEDICAL EXAMINER: [illegible]
DATE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9708

CERTIFICATE OF DEATH

Reg. Dist. No. 09717

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 9/2/58			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. STREET ADDRESS 118 Main Street			
3. NAME OF DECEASED (Type or print) First Blanche Middle L. Last Reece				4. DATE OF DEATH Month September Day 12 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/22/1878	9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months 7 Days 12 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Westernport, Maryland		11. BIRTHPLACE (State or foreign country) U. S. A.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME George Murphy			
14. MOTHER'S MAIDEN NAME Louise Morris				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. P.O. Box 599				17. INFORMANT Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial deterioration 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Senile psychosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Jaundice & Senile degeneration							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 9/2/58 , 19____, to 9/12/58 , 19____, that I last saw the deceased alive on 9/11/58 , 19____, and that death occurred at 7:30 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.				ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md.			
PHYSICIAN'S NAME (Type) Dr. James E. McLean				DATE SIGNED 9/12/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/15/58			
22c. NAME OF CEMETERY OR CREMATORY Philop				22d. LOCATION (City, town, or county) (State) Westernport Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Carl J. Boul				ADDRESS Westernport, Md.			
24a. REC'D BY REGISTRAR SEP 16 '58				24b. REGISTRAR'S SIGNATURE Arthur S. House			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09718

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

9707

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 414 E. Oldtown Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Reichert Last Reichert				4. DATE OF DEATH Month Sept. Day 25 Year 1958			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 17, 1869	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 8 Days 17		IF UNDER 24 HRS. Hours 17 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Julius Grabenstein				14. MOTHER'S MAIDEN NAME Susan Leidinger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Sr. Mary Leonita St. Mary's Convent	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardiovascular Disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1 Sudden							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 25, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-29-58		22c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR DATE SEP 30 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9743

CERTIFICATE OF DEATH

09719

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		c. LENGTH OF STAY IN 1b 78 Yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John First Simons Middle Robertson Last		4. DATE OF DEATH Month Sept. Day 11, Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 6, 1880
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Rail-road	
11. BIRTHPLACE (State or foreign country) Barton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Robertson		14. MOTHER'S MAIDEN NAME Catherine Simons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 712-14-1650	
17. INFORMANT Mrs. Helena Robertson-Barton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Renal Disease. 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerosis. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs 5yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15 , 19 58 , to Sep 11 , 19 58 , that I last saw the deceased alive on Sep 10 , 19 58 , and that death occurred at 7 a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 20 Green St Piedmont W Va DATE SIGNED			
ACTUAL SIGNATURE James H. Wolverton Sr M.D.			
PHYSICIAN'S NAME (Type) James H. Wolverton Sr Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/58	
22c. NAME OF CEMETERY OR CREMATORY Laurel Hill		22d. LOCATION (City, town, or county) (State) Moscow Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Bural		ADDRESS Westernport, Md.	
24a. REC'D BY REGISTRAR SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. DATE OF BIRTH 12-1-1928		6. PLACE OF BIRTH Jackson, Mississippi	
7. DATE OF DEATH 4-4-1968		8. TIME OF DEATH 10:00 AM		9. PLACE OF DEATH FBI Headquarters, Memphis, Tennessee	
10. CAUSE OF DEATH Suicide by gunshot		11. MANNER OF DEATH Homicide		12. MEDICAL HISTORY None	
13. SIGNATURE OF PHYSICIAN [Signature]		14. SIGNATURE OF CORONER [Signature]		15. SIGNATURE OF DEATH REGISTRAR [Signature]	
16. SIGNATURE OF WITNESS [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF WITNESS [Signature]	
19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF WITNESS [Signature]		21. SIGNATURE OF WITNESS [Signature]	
22. SIGNATURE OF WITNESS [Signature]		23. SIGNATURE OF WITNESS [Signature]		24. SIGNATURE OF WITNESS [Signature]	
25. SIGNATURE OF WITNESS [Signature]		26. SIGNATURE OF WITNESS [Signature]		27. SIGNATURE OF WITNESS [Signature]	
28. SIGNATURE OF WITNESS [Signature]		29. SIGNATURE OF WITNESS [Signature]		30. SIGNATURE OF WITNESS [Signature]	
31. SIGNATURE OF WITNESS [Signature]		32. SIGNATURE OF WITNESS [Signature]		33. SIGNATURE OF WITNESS [Signature]	
34. SIGNATURE OF WITNESS [Signature]		35. SIGNATURE OF WITNESS [Signature]		36. SIGNATURE OF WITNESS [Signature]	
37. SIGNATURE OF WITNESS [Signature]		38. SIGNATURE OF WITNESS [Signature]		39. SIGNATURE OF WITNESS [Signature]	
40. SIGNATURE OF WITNESS [Signature]		41. SIGNATURE OF WITNESS [Signature]		42. SIGNATURE OF WITNESS [Signature]	
43. SIGNATURE OF WITNESS [Signature]		44. SIGNATURE OF WITNESS [Signature]		45. SIGNATURE OF WITNESS [Signature]	
46. SIGNATURE OF WITNESS [Signature]		47. SIGNATURE OF WITNESS [Signature]		48. SIGNATURE OF WITNESS [Signature]	
49. SIGNATURE OF WITNESS [Signature]		50. SIGNATURE OF WITNESS [Signature]		51. SIGNATURE OF WITNESS [Signature]	
52. SIGNATURE OF WITNESS [Signature]		53. SIGNATURE OF WITNESS [Signature]		54. SIGNATURE OF WITNESS [Signature]	
55. SIGNATURE OF WITNESS [Signature]		56. SIGNATURE OF WITNESS [Signature]		57. SIGNATURE OF WITNESS [Signature]	
58. SIGNATURE OF WITNESS [Signature]		59. SIGNATURE OF WITNESS [Signature]		60. SIGNATURE OF WITNESS [Signature]	
61. SIGNATURE OF WITNESS [Signature]		62. SIGNATURE OF WITNESS [Signature]		63. SIGNATURE OF WITNESS [Signature]	
64. SIGNATURE OF WITNESS [Signature]		65. SIGNATURE OF WITNESS [Signature]		66. SIGNATURE OF WITNESS [Signature]	
67. SIGNATURE OF WITNESS [Signature]		68. SIGNATURE OF WITNESS [Signature]		69. SIGNATURE OF WITNESS [Signature]	
70. SIGNATURE OF WITNESS [Signature]		71. SIGNATURE OF WITNESS [Signature]		72. SIGNATURE OF WITNESS [Signature]	
73. SIGNATURE OF WITNESS [Signature]		74. SIGNATURE OF WITNESS [Signature]		75. SIGNATURE OF WITNESS [Signature]	
76. SIGNATURE OF WITNESS [Signature]		77. SIGNATURE OF WITNESS [Signature]		78. SIGNATURE OF WITNESS [Signature]	
79. SIGNATURE OF WITNESS [Signature]		80. SIGNATURE OF WITNESS [Signature]		81. SIGNATURE OF WITNESS [Signature]	
82. SIGNATURE OF WITNESS [Signature]		83. SIGNATURE OF WITNESS [Signature]		84. SIGNATURE OF WITNESS [Signature]	
85. SIGNATURE OF WITNESS [Signature]		86. SIGNATURE OF WITNESS [Signature]		87. SIGNATURE OF WITNESS [Signature]	
88. SIGNATURE OF WITNESS [Signature]		89. SIGNATURE OF WITNESS [Signature]		90. SIGNATURE OF WITNESS [Signature]	
91. SIGNATURE OF WITNESS [Signature]		92. SIGNATURE OF WITNESS [Signature]		93. SIGNATURE OF WITNESS [Signature]	
94. SIGNATURE OF WITNESS [Signature]		95. SIGNATURE OF WITNESS [Signature]		96. SIGNATURE OF WITNESS [Signature]	
97. SIGNATURE OF WITNESS [Signature]		98. SIGNATURE OF WITNESS [Signature]		99. SIGNATURE OF WITNESS [Signature]	
100. SIGNATURE OF WITNESS [Signature]		101. SIGNATURE OF WITNESS [Signature]		102. SIGNATURE OF WITNESS [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G234 10-1-58

CERTIFICATE OF DEATH

Reg. Dist. No.

09720

9744

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Daughter's home)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alphus Lee Ross		4. DATE OF DEATH Month Sept. Day 20 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1891
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
11. BIRTHPLACE (State or foreign country) Barton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Ross		14. MOTHER'S MAIDEN NAME Emma Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Richard Davis-Baltimore, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 weeks (c) years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 3, 19 58 , to September 20, 19 58 , that I last saw the deceased alive on September 20, 19 58 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2 B. ROADWAY DATE SIGNED 9/22/58 ACTUAL SIGNATURE John B. Davis, M.D. PHYSICIAN'S NAME (Type) John B. Davis, M.D. Frostberg, Md.			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/58	
22c. NAME OF CEMETERY OR CREMATORY Laurel Hill		22d. LOCATION (City, town, or county) (State) Moscow Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ed Bural		ADDRESS Westernport, Md.	
24a. REC'D BY REGISTRAR DATE SEP 25 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9725

CERTIFICATE OF DEATH

Reg. Dist. No.

09721

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS Main Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Janette Middle Schweikert Last Schweikert				4. DATE OF DEATH Month September Day 27 Year 19 58					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 6, 1881		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John McFarland				14. MOTHER'S MAIDEN NAME Margaret Tennent					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Kenneth Schweikert Staten Island, N.Y.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of "Stomach" 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from March , 19 57 , to Sept. 27 , 19 58 , that I last saw the deceased alive on Sept. 27 , 19 58 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) MAIN ST DATE SIGNED 9.29.58									
ACTUAL SIGNATURE Leslie R. Miles Jr. M.D.				PHYSICIAN'S NAME (Type) LESLIE R. MILES JR. M.D. LONA CONING M.D.					
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 9/30/58		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. RECEIVED BY REGISTRAR DATE OCT 2 58			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline					

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Name of Deceased		John Joseph	
Sex		Male	
Age		70	
Date of Birth		January 1, 1901	
Place of Birth		Somerville, Massachusetts, U.S.A.	
Usual Residence		Somerville, Massachusetts	
Cause of Death		Heart Disease	
Date of Death		January 1, 1971	
Place of Death		Somerville, Massachusetts	
Physician		Dr. [Name]	
Burial Place		St. [Name] Church, Somerville, Mass.	
Signature of Registrar		[Signature]	
Signature of Physician		[Signature]	
Signature of Family		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9709

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 1521 Furnace St.	
3. NAME OF DECEASED (Type or print) First Rose Middle Shanski Last Shanski		4. DATE OF DEATH Month 9 Day 14 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/5/71
9. AGE (In years lost birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 8 Days 14 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Maryland, Cumberland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Hensler		14. MOTHER'S MAIDEN NAME Mary Berg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Paul Shanski		18. ADDRESS 521 Furnace Street, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/5 , 19 58 , to 9/14 , 19 58 , that I last saw the deceased alive on 9/14 , 19 58 , and that death occurred at 11:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo H. Ley Jr.		DATE SIGNED 9/15/58	
PHYSICIAN'S NAME (Type) LEO H. LEY JR.		ADDRESS (Street, city or town, state) 456 N. Centre St. Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/58	
22c. NAME OF CEMETERY OR CREMATORY Sts. Peter & Paul Cath. Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR SEP 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9710

CERTIFICATE OF DEATH

09723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>117 So. Allegany St.</u>		d. STREET ADDRESS <u>117 So. Allegany St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Elizabeth</u> Last <u>Sheeche</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 9, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Hatherill</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Meggs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	
17. INFORMANT <u>Thomas Sheeche, 117 So. Allegany St. Cumb. Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>Coronary Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-19-56</u> , 19 <u>9-10-58</u> , that I last saw the deceased alive on <u>9-10-58</u> , 19 <u> </u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>62 Greene St.</u> DATE SIGNED <u>9-11-58</u> ACTUAL SIGNATURE <u>Ralph W. Ballin</u> M.D. PHYSICIAN'S NAME (Type) <u>Ralph W. Ballin, M.D.</u> <u>Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 13, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Bernards Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Indiana, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hous</u>			

200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9726

CERTIFICATE OF DEATH

Reg. Dist. No.

09724

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b X Midland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charles Middle A. Last Sigler				4. DATE OF DEATH Month September Day 5 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 25, 1870		9. AGE (In years lost birthday) yrs. 88	IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min. 88	IF UNDER 24 HRS. Months 88 Days 88 Hours 88 Min. 88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Westernport, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Francis Lease Address Midland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Arterio Sclerosis (c) ?						INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 30, 1958 to Sept 3, 1958 , that I last saw the deceased alive on Sept 3, 1958 , and that death occurred at 9:55 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Worm Lane M.D.				ADDRESS (Street, city or town, state) Frostburg Sept DATE SIGNED 1958			
PHYSICIAN'S NAME (Type) Worm Lane M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/58		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md.				24a. REC'D BY REGISTRAR DATE SEP 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

Item 20 Film 234 10-3-58
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7 miles southeast of Flintstone</u>				c. LENGTH OF STAY IN 1b <u>X</u> Route 1, Oldtown,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rural near Flintstone</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Raymond Marcellus Slider</u>				4. DATE OF DEATH Month Day Year <u>September 23 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1926</u>	9. AGE (in years last birthday) <u>31</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>	
13. FATHER'S NAME <u>Marcellus L/ Slider</u>				14. MOTHER'S MAIDEN NAME <u>Elenor Haugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Mrs. Raymond Slider Oldtown, Maryland</u>				Address <u>Rt. 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Chest</u> <u>835X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fractured skull</u> (c) <u>5 min.</u> DUE TO (a), stating the underlying cause lost. (c) <u>5 min.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (private bridge on farm) <u>Bridge collapsed under tractor he was driving</u>			
20c. TIME OF INJURY Hour <u>2:30</u> P. M. Month, Day, Year <u>9/23/58</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. (City or town) (County) (State) <u>RFD#1 Oldtown Allegany, Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept 23, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 26, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09726

9711

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 20 mo., 20 das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Smith Last Smith		4. DATE OF DEATH Month September Day 3 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1882
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11b. KIND OF BUSINESS OR INDUSTRY Maryland	
12. BIRTHPLACE (State or foreign country) Maryland		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Peter Smith		15. MOTHER'S MAIDEN NAME Jennie Scott	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. 305-1721	
18. INFORMANT Mrs. Alvin Ternent		Address Lonaconing, Md.	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 333 Cerebral Thrombosis. 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 443 Chronic Hypertension DUE TO (c) 593 Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 305-1721 Presence with psychotic reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 14, 1936 to Sept. 3, 1958 , that I last saw the deceased alive on Sept. 2, 1958 , and that death occurred at 10 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Fremont DATE SIGNED 9-3-58	
PHYSICIAN'S NAME (Type) James E. McLean, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/5/58	22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	22d. LOCATION (City, town, or county) (State) Lonaconing, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md	
24a. REC'D BY REGISTRAR SEP 9 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

CERTIFICATE OF DEATH

1911

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>	
<p>4. Date of death</p>		<p>5. Time of death</p>		<p>6. Place of death</p>	
<p>7. Cause of death</p>		<p>8. Manner of death</p>		<p>9. Signature of physician</p>	
<p>10. Signature of registrar</p>		<p>11. Signature of informant</p>		<p>12. Signature of witness</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9712

CERTIFICATE OF DEATH

09727

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 9 HRS.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND CRESAPTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.		d. STREET ADDRESS 11 MEADOW DRIVE	
3. NAME OF DECEASED (Type or print) First Middle Last STEINBERGER		4. DATE OF DEATH Month Day Year SEPT 1 19 58	
5. SEX F	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/58
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RUDOLPH STEINBERGER		14. MOTHER'S MAIDEN NAME GENEVA XX GUAS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (24 wks) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4.00 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Fuller B Whitworth MD, Cumberland, Md 2 Sept 58 PHYSICIAN'S NAME (Type) DR. FULLER B. WHITWORTH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Sept 2, 1958	
22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
DATE SEP 4 '58			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9713 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09728

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.Va. b. COUNTY Mineral									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 4 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wiley Ford, W.Va. 85X-3									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital--Cumb. Md.				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Ronald Scott Tabler		4. DATE OF DEATH Month Sept. Day 7 Year 19 58		5. SEX Male									
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 9, 1958									
9. AGE (In years last birthday) 29 yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td>2</td> <td>29</td> <td></td> <td></td> </tr> </table>		Months	Days	Hours	Min.	2	29			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
Months	Days	Hours	Min.										
2	29												
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME Ronald Tabler				14. MOTHER'S MAIDEN NAME Patty Rummer									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Memorial Hospital--Cumberland, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adrenal Hemorrhage 057.1 DUE TO Waterhouse-Freiderichsen Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) </div> <div style="width: 15%; text-align: right;"> INTERVAL BETWEEN ONSET AND DEATH 4 Hrs. </div> </div>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				DATE SIGNED Sept. 7, 1958									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-8-58		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park									
22d. LOCATION (City, town, or county) Cumberland, Md.		22e. (State)											
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE SEP 9 '58									
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hantz</i>													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9714

CERTIFICATE OF DEATH

Reg. Dist. No.

09729

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>19 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nannie</u> Middle <u>E.</u> Last <u>Tyree</u>		4. DATE OF DEATH Month <u>9</u> Day <u>23</u> Year <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/10/74</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Drain</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of spine</u> <u>196.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/30</u> , 19 <u>58</u> , to <u>9/23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/23</u> , 19 <u>58</u> , and that death occurred at _____ M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>R. W. Trevaskis, Sr.</u> M.D. <u>Cumberland, Maryland</u>		<u>9/24/58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Trevaskis, Sr.</u>		<u>220 Baltimore Ave.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Buena Vista, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u> ADDRESS <u>Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR <u>SEP 26 58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Robert S. Harris</u>	

CERTIFICATE OF DEATH

STATE OF NEW YORK

APPROPRIATE
DEPARTMENT OF HEALTH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Date of Death: _____

7. Time of Death: _____

8. Cause of Death: _____

9. Place of Death: _____

10. Signature of Physician: _____

11. Signature of Registrar: _____

12. Date of Registration: _____

13. Name of Registrar: _____

14. Address of Registrar: _____

15. City: _____

16. State: _____

17. Zip: _____

18. Name of Hospital: _____

19. Address of Hospital: _____

20. City: _____

21. State: _____

22. Zip: _____

23. Name of Doctor: _____

24. Address of Doctor: _____

25. City: _____

26. State: _____

27. Zip: _____

28. Name of Nurse: _____

29. Address of Nurse: _____

30. City: _____

31. State: _____

32. Zip: _____

33. Name of Family: _____

34. Address of Family: _____

35. City: _____

36. State: _____

37. Zip: _____

38. Name of Friend: _____

39. Address of Friend: _____

40. City: _____

41. State: _____

42. Zip: _____

43. Name of Neighbor: _____

44. Address of Neighbor: _____

45. City: _____

46. State: _____

47. Zip: _____

48. Name of Other: _____

49. Address of Other: _____

50. City: _____

51. State: _____

52. Zip: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9746 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09730

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

W. Va.

b. COUNTY

Mineral

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Cumberland

c. LENGTH OF STAY IN

traveling

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Elk Garden

85X-3

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Route 5,

d. STREET ADDRESS

Near Hartmansville

e. IS RESIDENCE
ON A FARM?
YES ☒ NO ☐

**3. NAME OF
DECEASED**
(Type or print)

First

Middle

Last

Hiram Eyra

Van Meter

**4. DATE
OF DEATH**

Month

Day

Year

Sept. 13

1958

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ **NEVER MARRIED** ☐

WIDOWED ☐ **DIVORCED** ☐

8. DATE OF BIRTH

Sept. 3, 1913

9. AGE (In years
last birthday)

45 yrs.

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Miner

10b. KIND OF BUSINESS OR INDUSTRY

Coal mines

11. BIRTHPLACE (State or foreign country)

W. Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Van Meter

14. MOTHER'S MAIDEN NAME

Minnie Rohrbaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

236 12 9043

17. INFORMANT

Address

Sharpless Funeral Home, Blaine, W. Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Crushed Skull

**INTERVAL BETWEEN
ONSET AND DEATH**

Sudden

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

**19. WAS AUTOPSY
PERFORMED?**
YES ☒ NO ☐

**20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Overturnd in an Automobile

20c. TIME OF INJURY

Month, Day, Year

5:00 p. m. 9/13 1958

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Street

20f. (City or town)

Rt. 220

(County)

Alleg. Md.

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

**ACTUAL
SIGNATURE**

Benedict Skitarelic

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DATE SIGNED

**EXAMINER'S
NAME (Type)**

Benedict Skitarelic, M.D.

DEPUTY MEDICAL EXAMINER ☒

Sept. 13, 1958

**22a. BURIAL, CREMATION,
REMOVAL (Specify)**

Burial

22b. DATE THEREOF

9/16/1958

22c. NAME OF CEMETERY OR CREMATORY

Maysville Cemetery

22d. LOCATION (City, town, or county)

Maysville, W. Va.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Syron Light Cumberland, Md.

ADDRESS

24a. REC'D BY REGISTRAR
SEP 16 '58
DATE

24b. REGISTRAR'S SIGNATURE

Arthur S. Huns

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9715

CERTIFICATE OF DEATH

09731

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 32 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 121 West First Street				d. STREET ADDRESS 121 West First Street			
3. NAME OF DECEASED (Type or print) First Bessie Middle Lee Last Wakeman				4. DATE OF DEATH Month 9 Day 2 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-7-1894		9. AGE (In years last birthday) yrs. 63	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY School Cafeteria		11. BIRTHPLACE (State or foreign country) Edinburg, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin G. Mc Inturff				14. MOTHER'S MAIDEN NAME Elizabeth Bowman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-10-7490		17. INFORMANT Address Mr. Charles H. Wakeman, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of uterus 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 18 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Aug 5th 1958 to Sept 24th 1958 , that I last saw the deceased alive on Sept 1st 1958 , and that death occurred at 8:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 220 Baltimore Ave, Cumberland, Md. DATE SIGNED 9-3-1958							
ACTUAL SIGNATURE R. W. Trevaskis				DATE SIGNED 9-3-1958			
PHYSICIAN'S NAME (Type) Dr. R. W. Trevaskis				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-58		22c. NAME OF CEMETERY OR CREMATORY Mc Inturff Cemetery		22d. LOCATION (City, town, or county) (State) Fort Powells Valley, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE SEP 4 '58		24b. REGISTRAR'S SIGNATURE Arthur S. House	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 12

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES P. McNEIL		45		M		W		1880		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
1234 Main St., Boston, Mass.		Carpenter		Heart Disease		Natural		Jan 15, 1925		Boston		Boston		Massachusetts		United States	
Physician		Attending Physician		Medical Examiner		Burial		Burial		Burial		Burial		Burial		Burial	
Signature of Physician		Signature of Medical Examiner		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer	
J. W. Smith		D. E. Jones		A. B. White		A. B. White		A. B. White		A. B. White		A. B. White		A. B. White		A. B. White	
Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death	
Jan 15, 1925		Jan 15, 1925		Jan 15, 1925		Jan 15, 1925		Jan 15, 1925		Jan 15, 1925		Jan 15, 1925		Jan 15, 1925		Jan 15, 1925	
Place of Death		Place of Death		Place of Death		Place of Death		Place of Death		Place of Death		Place of Death		Place of Death		Place of Death	
Boston		Boston		Boston		Boston		Boston		Boston		Boston		Boston		Boston	
State of Death		State of Death		State of Death		State of Death		State of Death		State of Death		State of Death		State of Death		State of Death	
Massachusetts		Massachusetts		Massachusetts		Massachusetts		Massachusetts		Massachusetts		Massachusetts		Massachusetts		Massachusetts	
Country of Death		Country of Death		Country of Death		Country of Death		Country of Death		Country of Death		Country of Death		Country of Death		Country of Death	
United States		United States		United States		United States		United States		United States		United States		United States		United States	

RECORDED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9716

CERTIFICATE OF DEATH

09732

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11/14/57		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				d. STREET ADDRESS 47 Linden Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Melvin Middle M. Last Ward				4. DATE OF DEATH Month September Day 15 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/1/1871	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Bricklayer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wellersburg, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Pinkney P. Ward				14. MOTHER'S MAIDEN NAME Rebecca Gallagher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT P.O.Box 599 Address Cumberland, Md. Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, chronic, Senile 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis, Arterial, Senile DUE TO (c) Arterio Sclerosis, & deceleration							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/14/57 , 19____, to 9/15/58 , 19____, that I last saw the deceased alive on 9/15/58 , 19____, and that death occurred at 10:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 9/16/58							
ACTUAL SIGNATURE R. Mathews		M.D. Dr. Lee B. Mathews		Cumberland, Md.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-18-58		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE SEP 18 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
OCCASION OF DEATH [REDACTED]		PLACE OF BIRTH [REDACTED]		DATE OF BIRTH [REDACTED]	
NAME OF PHYSICIAN [REDACTED]		NAME OF FUNERAL HOME [REDACTED]		NAME OF BURIAL PLACE [REDACTED]	
NAME OF NEXT OF KIN [REDACTED]		NAME OF WITNESS [REDACTED]		NAME OF REGISTRAR [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF FUNERAL HOME [REDACTED]		SIGNATURE OF BURIAL PLACE [REDACTED]	
SIGNATURE OF NEXT OF KIN [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]	

CERTIFICATE OF DEATH

09733

Reg. Dist. No.

9717

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND.				c. LENGTH OF STAY IN 1b 6 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MABLE Middle Imes Last WETZEL				4. DATE OF DEATH Month SEPTEMBER Day 7 Year 19 58			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1883		9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed seamstress			10b. KIND OF BUSINESS OR INDUSTRY Tailoring		11. BIRTHPLACE (State or foreign country) Chaneyville, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME LEWIS IMES				14. MOTHER'S MAIDEN NAME ANN BROWNING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 220-30-8503		17. INFORMANT Lt. Col. E. Leo Morrissey Address 910 Holland St., Cumb.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Congestive Heart Failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 hrs 5 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cumberland, Md.				20g. (County) (State)			
21. I certify that I attended the deceased from 9-6 , 19 58 , to 9-7 , 19 58 , that I last saw the deceased alive on 9-7 , 19 58 , and that death occurred at 10:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 9-7-58							
ACTUAL SIGNATURE William J. James M.D.				DATE SIGNED 9-7-58			
PHYSICIAN'S NAME (Type) W. P. JAMES				ADDRESS Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/58		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE William J. James	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED ALBERTA		SEX FEMALE		AGE 45	
PLACE OF BIRTH ALABAMA		RACE WHITE		DATE OF BIRTH 1910	
OCCUPATION SEWING		MARITAL STATUS SINGLE		PLACE OF DEATH BALTIMORE, MD	
DATE OF DEATH 1955		TIME OF DEATH 10:00 AM		PLACE OF INTERMENT GREENWICH CEMETERY	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		SIGNATURE OF PHYSICIAN J. B. WELLS	
SIGNATURE OF REGISTRAR J. B. WELLS		SIGNATURE OF WITNESS J. B. WELLS		SIGNATURE OF DECEASED ALBERTA	

RECORDED BY A-114

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09734

9727

CERTIFICATE OF DEATH

Reg. Dist. No.

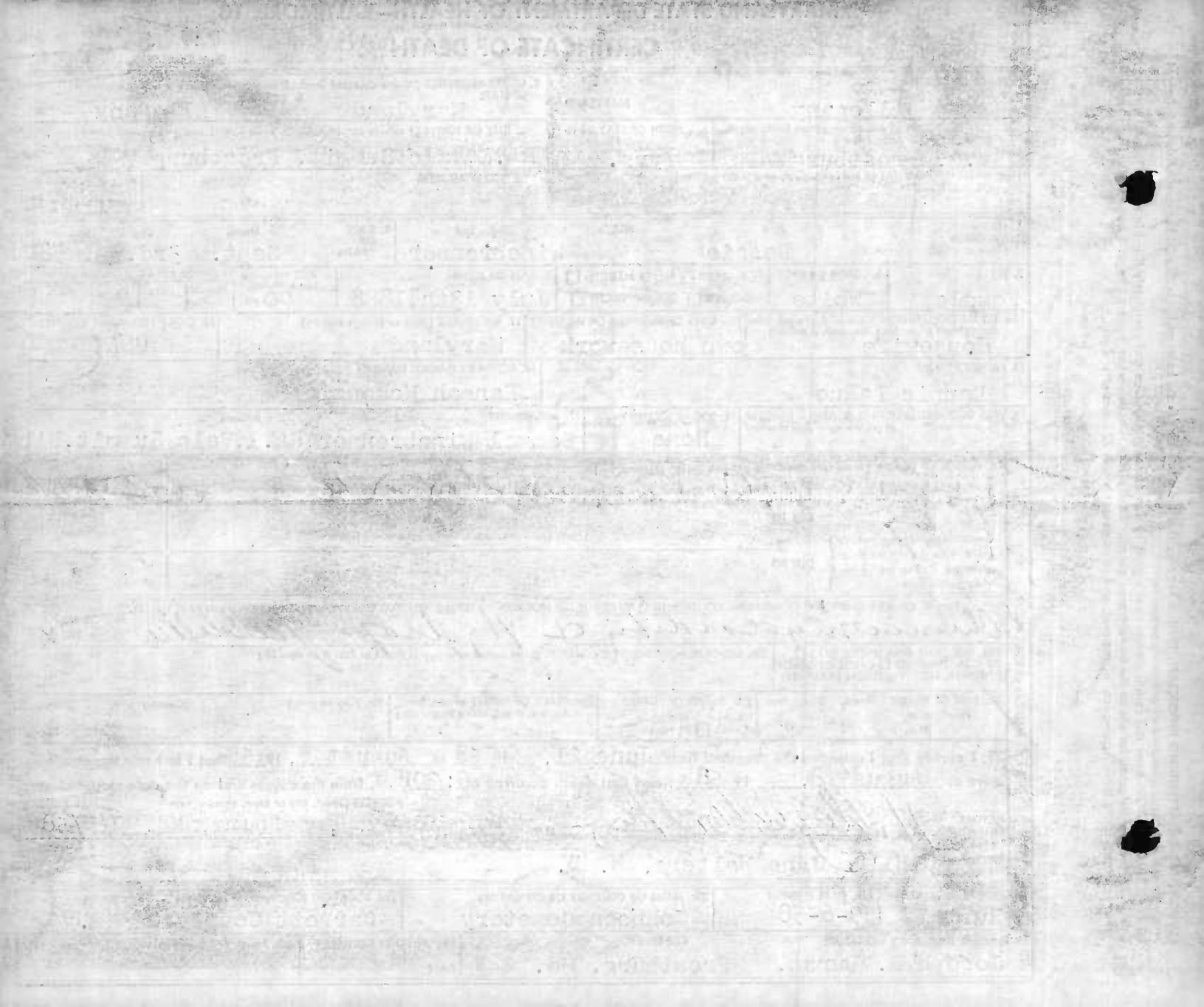
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b Lifetime					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 232 Center St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Charles Isaac Williams				4. DATE OF DEATH 22 Frostburg					
5. SEX Male				6. COLOR OR RACE Colored					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Mar. 2 1877					
9. AGE (In years last birthday) 81 yrs.				10. IF UNDER 1 YEAR 27 19 58					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Brick Yard					
11. BIRTHPLACE (State or foreign country) Frostburg, Md.				12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Rosa A. Williams					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-10-7326					
17. INFORMANT Ida Belle Gordon				Address 232 Center Street, Frostburg, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 422.1 DUE TO arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 1 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1958 to Sept 27, 1958 , that I last saw the deceased alive on Sept 26, 1958 , and that death occurred at 4:20 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) Frostburg, Md. DATE SIGNED Sept 24 1958									
ACTUAL SIGNATURE WOM Lane M.D.				PHYSICIAN'S NAME (Type) WOM Lane					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-30-1958		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Pk. Frostburg		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Haier				24a. REC'D BY REGISTRAR DATE OCT 1 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. 1, Frostburg</u>		c. LENGTH OF STAY IN 1b <u>9 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. 1, Vale Summit, Frostburg</u>	
		d. STREET ADDRESS <u>/</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dessie</u> Middle <u>Winebrenner</u> Last <u>Winebrenner</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>3rd</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13th, 1888</u>
9. AGE (In years last birthday) <u>70 yrs.</u>		10. IF UNDER 1 YEAR Months <u>70</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dennis LaRue</u>		14. MOTHER'S MAIDEN NAME <u>Hannah McKenzie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>215-16-9900</u>	
17. INFORMANT Address <u>Samuel Winebrenner, Rt. 1, Vale Summit, F'bg</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic myocarditis & Hydrops Gallbladder</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June 21</u> , 19 <u>58</u> , to <u>August 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 8</u> , 19 <u>58</u> , and that death occurred at <u>8:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hilda Jane Walters</u>		M.D. <u>48 Broadway, Frostburg, Md.</u> DATE SIGNED <u>9/4/58</u>	
PHYSICIAN'S NAME (Type) <u>Hilda Jane Walters, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-6-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Johnson Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Garrett County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst,</u>		ADDRESS <u>Frostburg, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 8 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	



9729

CERTIFICATE OF DEATH

09736

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mt. Savage	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				f. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GAIL Middle E. Last WINEBRENNER				4. DATE OF DEATH Month Sept. Day 4 Year 1958			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 1, 1958	
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.		IF UNDER 24 HRS. Months 3 Days 3 Hours 3 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Fred Winebrenner				14. MOTHER'S MAIDEN NAME Virginia Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Fred Winebrenner, Mt. Savage, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 273X Enlarged Thyroid Status Thyræotoxic DUE TO Constructing major blood vessels (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/1/58 , 19 58 , to 9/4/58 , 19 58 , that I last saw the deceased alive on 9/4/58 , 19 58 , and that death occurred at 5:50 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 Broadway DATE SIGNED 9/5/58 ACTUAL SIGNATURE Martin Rothstein M.D. PHYSICIAN'S NAME (Type) Martin Rothstein, M. D. FROSTBURG - MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-58		22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE SEP 8 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9718 CERTIFICATE OF DEATH

09737

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 615 Sedgwick Street		d. STREET ADDRESS 615 Sedgwick Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle Jacob Last Winfield		4. DATE OF DEATH Month Sept. Day 30 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1886
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Tin Mill	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Winfield		14. MOTHER'S MAIDEN NAME Catherine Liobel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-30-0384	
17. INFORMANT Mrs. Leo Palmer		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 451x IMMEDIATE CAUSE (a) Abdominal aneurysm DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-21, 1958 , to 9-30, 1958 , that I last saw the deceased alive on 9-30, 1958 , and that death occurred at 6 p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 10-2-58 ACTUAL SIGNATURE Ralph W. Ballin M.D. PHYSICIAN'S NAME (Type) Ralph W. Ballin Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 3, 1958	
22c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24a. REC'D BY REGISTRAR DATE OCT 6 '58	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09738

Reg. Dist. No.

9719

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN lb <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>223 Baltimore Street</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>223 Baltimore Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>E.</u> Last <u>Wise</u>		4. DATE OF DEATH Month <u>September</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 18, 1893</u>	9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Stores</u> 11. BIRTHPLACE (State or foreign country) <u>Hyndman Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Robert DeVore</u> 14. MOTHER'S MAIDEN NAME <u>Christine Rice</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-16-5967</u> 17. INFORMANT <u>Edwin Robt Wise</u> Address <u>261 Kent Drive Manassas Park Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarolic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarolic M.D.</u>		DATE SIGNED <u>Sept. 20, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 23, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hyndman Cemetery</u>	22d. LOCATION (City, town, or county) <u>Hyndman Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hofer</u> ADDRESS <u>Cumberland Md</u>		24a. REC'D BY REGISTRAR <u>SEP 24 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hoad</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9720

Reg. Dist. No. 80739

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.Va. b. COUNTY HAMPSHIRE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Augusta 85x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS Mem. Hosp. Cumberland, Md.	
3. NAME OF DECEASED (Type or print) First Audrey Middle J. Last Wolfe		4. DATE OF DEATH Month Sept. Day 23 Year 1958	
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20 1912
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 2 Days 3	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Daugherty		14. MOTHER'S MAIDEN NAME LETA SAVILLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mem. Hosp.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 916.2 IMMEDIATE CAUSE (a) Third and Fourth Degree Burns, DUE TO Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 10 Hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Kerosene burns	
20c. TIME OF INJURY Month, Day, Year 9:00 AM 9/23/ 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Augusta W.Va.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		DATE SIGNED Sept. 23, 1958	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/1958	
22c. NAME OF CEMETERY OR CREMATORY St. Ignace		22d. LOCATION (City, town, or county) (State) Augusta Rural	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. McKee		24a. REC'D BY REGISTRAR SEP 26 '58	
ADDRESS Augusta		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 15 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARIA Middle ZUMPARNO Last		4. DATE OF DEATH Month Sept Day 2 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-1878
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Arnone		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-10-2155A	
17. INFORMANT Mrs. Anthony Zumpano, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 26 mo ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1 , 19 58 , to Sept 2 , 19 58 , that I last saw the deceased alive on Sept 1 , 19 58 , and that death occurred at 1:20 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE WOMC Lane M.D.		DATE SIGNED Sept 2 1958	
PHYSICIAN'S NAME (Type) WOMC Lane MD		Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-4-58	
22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR DATE SEP 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

